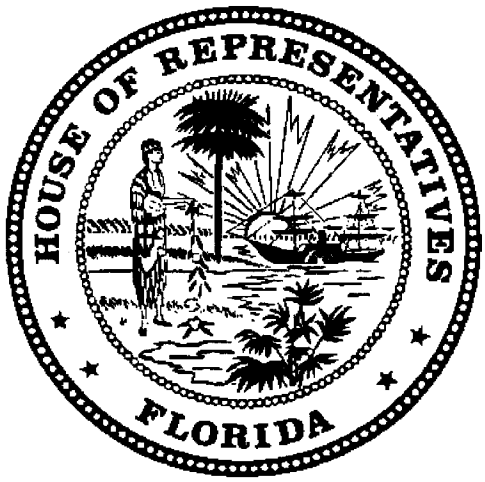


Future of Florida's Families Committee

Prevention of Child Abuse and Neglect Public Hearing

Monday, October 3, 2005
1:00 p.m. – 4:00 p.m.
Miami City Hall (Main Chambers)
Miami, Florida

Allan Bense
Speaker

Bill Galvano
Chair

Florida House of Representatives

Future of Florida's Families Committee

PREVENTION OF CHILD ABUSE AND NEGLECT PUBLIC HEARING

Monday, October 3, 2005
1:00 p.m. – 4:00 p.m.
Miami City Hall
Miami, Florida

THEMES: **PROFILE OF A CHILD ABUSER – Risk Factors for Child Abuse and Neglect: Alcohol Abuse; Substance Abuse; Mental Illness; Poverty; Childhood Physical or Sexual Abuse; Domestic Violence; and Lack of Parenting or Communication Skills -- WHAT RESEARCH IS TELLING US – Protective Factors for Child Abuse and Neglect: Child Factors, Parent and Family Factors, and Social and Environmental Factors**

1:00 – 1:15	Opening Remarks by Chair Galvano and Introduction of Members
1:15 – 1:30	Ellyn Okrent, LCSW, Executive Vice President Kids In Distress, Ft. Lauderdale
1:30 - 1:50	Holly Hills, Ph.D., Associate Professor, Department of Mental Health Law and Policy, Florida Mental Health Institute, University of South Florida
1:50 – 2:05	Barbara F. Foster, Ph.D., Executive Director The Florida Commission on Marriage and Family Support Initiatives
2:05 – 2:20	Mary Ann Kershaw, Research Faculty Member, Department of Child & Family Studies, Florida Mental Health Institute, University of South Florida
2:20 – 2:30	Silvia Quintana, District Program Supervisor for Substance Abuse and Mental Health, Florida Department of Children and Families
2:30 – 2:45	Walter Lambert, M.D., Medical Director, Miami-Dade and Monroe Counties Associate Professor of Pediatrics, University of Miami
2:45 - 3:15	QUESTIONS AND ANSWERS
3:15 – 4:00	**PUBLIC TESTIMONY**

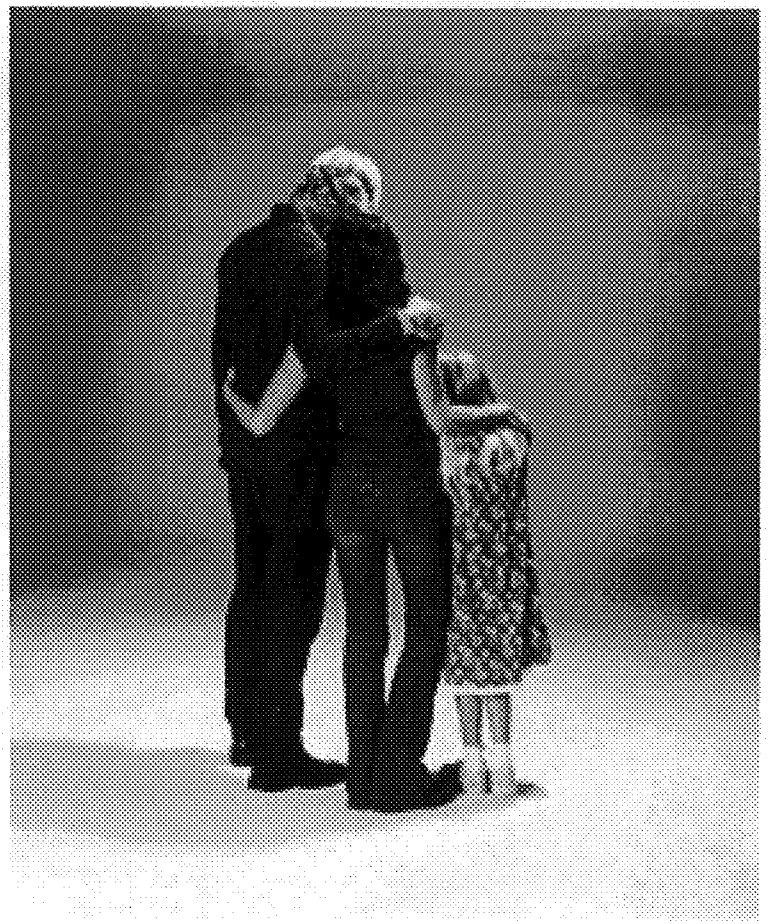
214 House Office Building, 402 South Monroe Street Tallahassee, Florida 32399-1300 (850) 488-8315

Ellyn Okrent, LCSW

KIDS IN DISTRESS

A Holistic Approach to the Prevention of Child Abuse

The Coordinated Family Services Program



A comprehensive family support model encompasses the philosophy that in order to improve the lives of children with complex needs, the process must be child centered and family focused, with maximum family involvement.

KIDS IN DISTRESS

With Funding From

- Children's Services Council
- Children's Services Administration
- ChildNet
- United Way
- Medicaid
- DCF
- SAMH
- Kids In Distress (KID)
- Healthy Start
- Family Central
- Mental Health Association of Broward County (MHA),
- Children's Diagnostic and Treatment Center (CDTC)
- Broward Children's Center (BCC)
- Therapeds
- Workforce One
- Women in Distress
- Broward Addition Recovery Center (BARC)
- The Glass House
- Healthy Families

These agencies have entered into a collaborative partnership that utilizes a combination of best practice approaches and model:

Specifically, these agencies address the multiple issues that families have in a coordinated manner.

KIDS IN DISTRESS

The Goals of the Coordinated Family Services Program

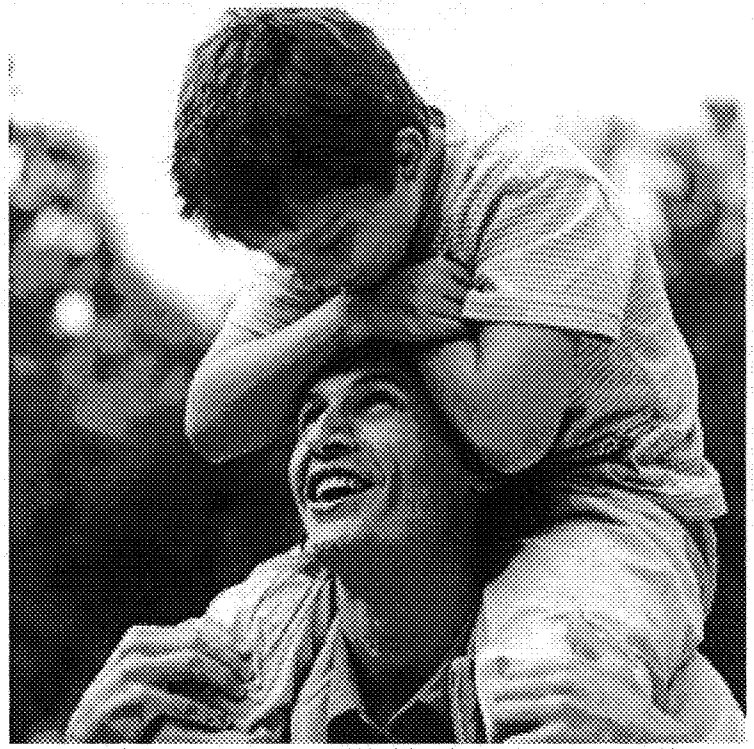
- to prevent children who are considered at-risk from being removed from their families
- to provide services and resources that are necessary for at-risk families to maintain their families intact
- to assist at risk families in their efforts to attain and achieve identified case plan tasks while approaching healthy permanency
- to provide comprehensive and convenient court ordered services to parents who's children have been removed with the goal or achieving the time required permanency, either reunification or termination of parental rights.

KIDS IN DISTRESS

The Key Assumption

The model draws on a variety of theoretical orientations, from crisis intervention to family therapy, with an emphasis on cognitive and behavioral change.

It stresses the need to respond to multiple causes of the family's distress by providing both family intervention and concrete services (finances, budgeting, job finding, healthcare, advocacy, etc.) that address the needs of all family members.



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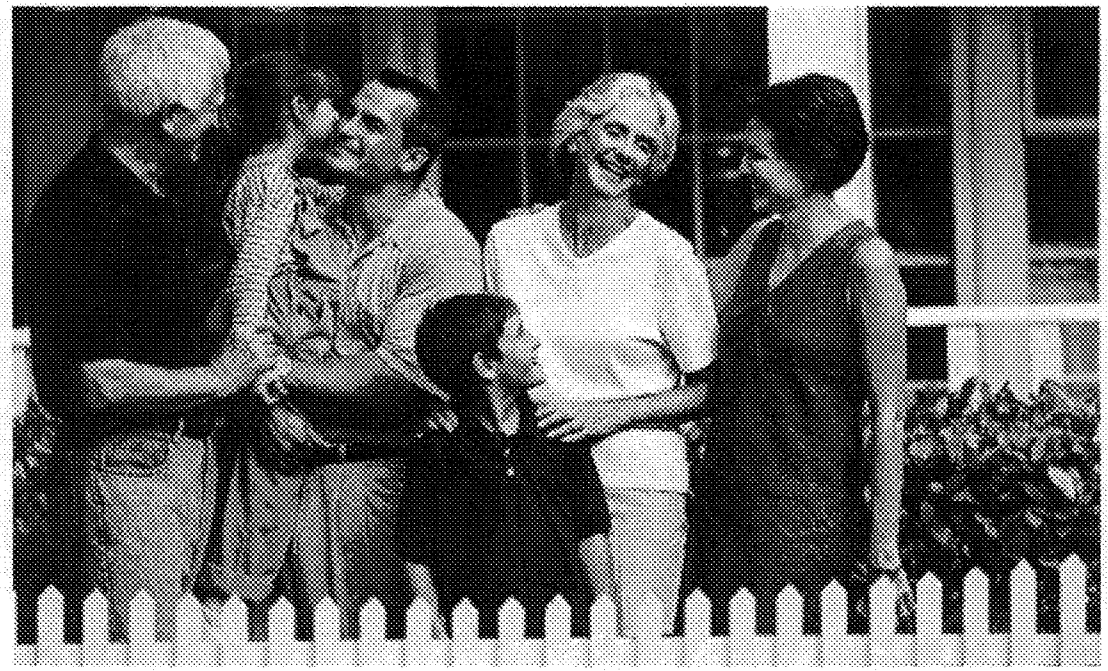
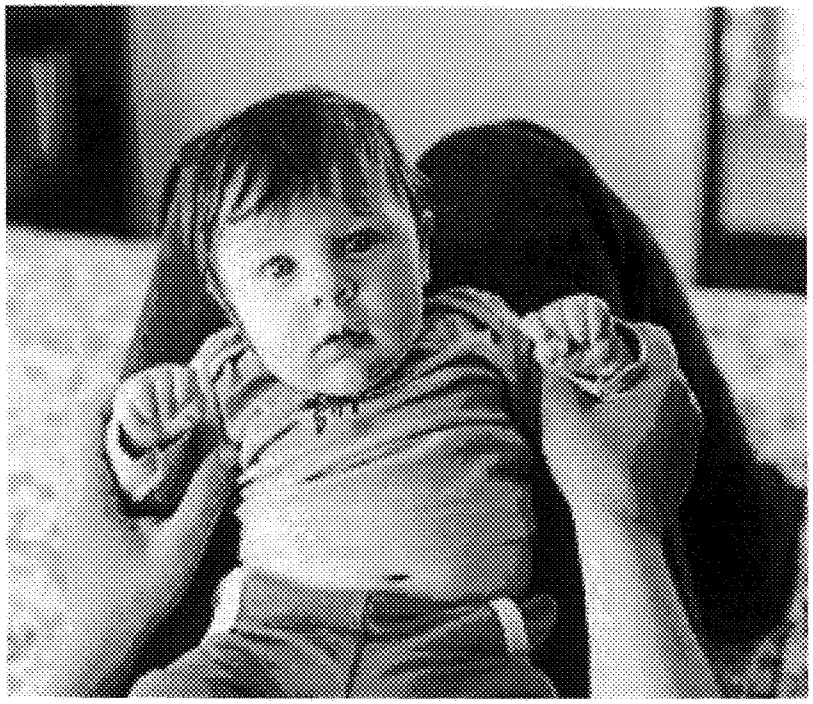


The Program is based on the Philosophy that:

- children should remain with their families whenever possible
- that families are constantly engaged in a process of growth and development
- that all families have strengths on which to build upon

Eligibility

Services are available to families with allegations of abuse and/or neglect and/or are at risk of having their children removed from their homes. Families referred must have documented "Risk" factors of at least three or more of the following:

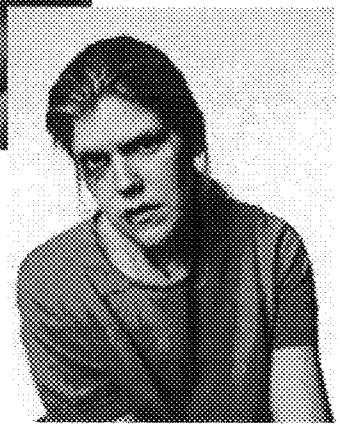


- Documented history of child abuse or neglect with either the parent or children
- Disruptions in bonding and attachment between parent and child
- Persistent, serious family conflict or family violence
- Persistent, serious family stress which significantly impacts family functioning
- Family history of substance abuse

KIDS IN DISTRESS

- Caregivers have negative attitudes and lack knowledge
- Regarding appropriate child development that lead to unrealistic.
- Expectations of the child
- Documented history of family management problems, poor.
- Parental supervision, and/or inappropriate or severe discipline practices.
- Involvement with the juvenile justice system
- Low income, single parent household
- Parent or child depression or other mental or behavioral conditions.
- Teen Pregnancy
- Children that have been removed from their homes for reasons of confirmed abuse and/or neglect and are residing in group homes, shelters and/or foster or pre-adoptive homes
- Families that are working toward reunification with their children and permanency.

KIDS IN DISTRESS



Any of the following factors will deem a referral inappropriate for Coordinated Family Services due to the immediate danger, as they require immediate crisis intervention:

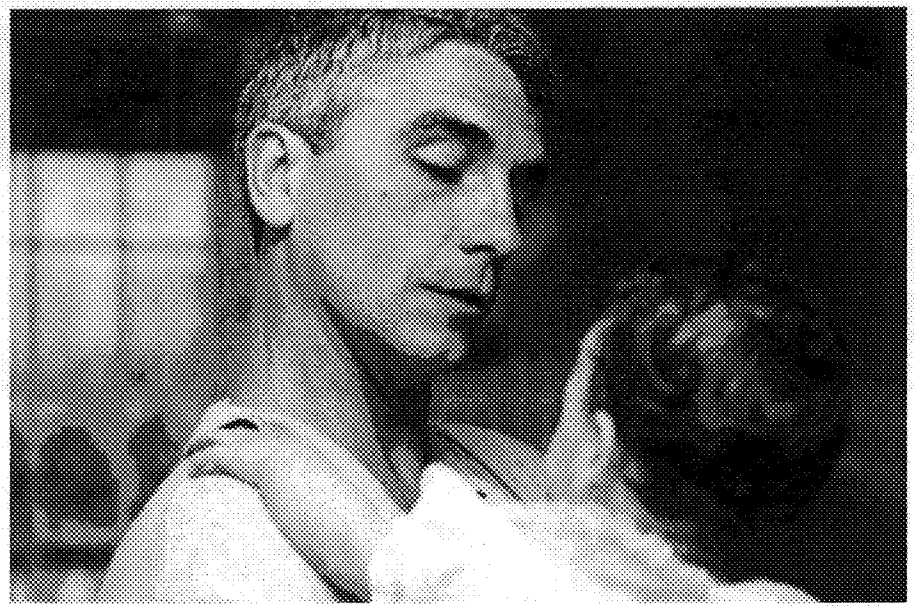
- Confirmed "immanent risk" of a child
- Active Domestic Violence
- Suicidal Ideation by any family member
- Homicidal Ideation by any family member

Immediate Crisis Stabilization

The professional's first responsibility is to help stabilize any immediate safety concerns or crisis issues. No person in great stress or who is concerned about personal or family safety can enter fully into an important relationship or begin the strengths, needs and culture assessment.

KIDS IN DISTRESS

The Most Important Step of the Process



The most important step of the process is the strengths, needs and culture discovery. **Deficit-based plans have likely already been tried without positive outcomes**. A comprehensive strengths, needs and culture discovery will permit the plan to include strength-based options for meeting the needs of the child and family that reflect the culture of the family.

Encourage as many family members and other individuals who know the child and family well, and who the family wants involved, to participate in the strengths, needs and culture discovery interview.

Many families will find it difficult at first to identify their strengths. This may be due to the fact that it is human nature to focus only on their deficits, and they are in need of services because of some negative situation.

KIDS IN DISTRESS

Services Include

Child Centered

Services and supports are provided in the best interest of the child to ensure that the child's needs (physical, emotional, educational, spiritual, safety and permanence) are being met.

Family-Focused

The child is viewed as a part of the whole family system and services and supports are based on the strengths and needs of the entire family.

Safety (Child, Family, and Community)

Services and supports are developed to best ensure the safety of the child, family and community. Safety plans are based on an assessment of risk and are developed with the family to reduce these risks.

Individualized and Culturally Competent

KIDS IN DISTRESS

Family Preservation Services Include

- Initial Assessment
- Development of Support Systems
- Development of family preservation plan, with full participation of the family
- Individual Advocacy
- Case Management

  Information and referrals
  - Therapies
  - Medical Care
  - Psychiatric Care
  - Housing
  - Shelter
- Assistance in job, search, placement and training
- Life Skills training to include:

  Nutrition

  Health Care

  Money Management

  Household Maintenance

- Parent Skills Development
  - Modeling appropriate parenting techniques
  - Relationship building
  - Improving communication skills
- 24 hour/7 day a week telephone crisis intervention
- Communication and conflict resolution skills training

- School advocacy
- Court Advocacy
- Group and individual counseling addressing substance abuse issues (including assessment/intervention groups, treatment groups, and relapse prevention groups)
- Group and individual counseling addressing domestic violence issues (batter's intervention, individual and group counseling for victims, anger management psycho-educational groups, and children's groups designed for childe exposed to domestic violence)
- Group and individual counseling addressing court ordered parent skills training
- Group and individualized therapy and support services addressing social and emotional issues
- In-home reunification services (including any services listed above as needed)
- In-home transition support to relative caregivers and/or adoptive homes (to include all services listed above as needed)

- Meals on group and individual therapy nights
- Childcare is provided while parents are in groups
- Limited access to flex funds for specific family needs (including bus passes for client transportation to an from service provider)
- Court ordered supervised visitation
  - ➢Supervised visits
  - ➢Therapeutic visits
  - ➢Monitored exchange

KIDS IN DISTRESS

The Plan

The plan is based on the unique strengths, needs, values, norms, preferences and cultures of the family.

The plan is focused on the typical needs in the areas that all people have, such as like age, sex and culture, and include:

- independence
- family circumstances
- finances
- education
- health
- social/recreation
- behavior/emotional
- psychological
- legal
- safety

KIDS IN DISTRESS

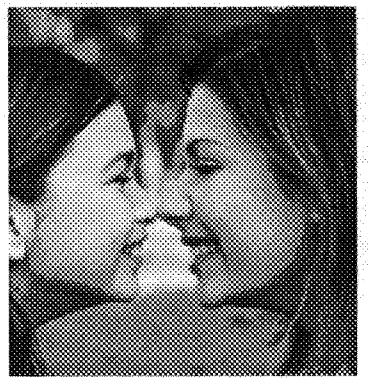
Identifying, Developing, and Engaging Natural Supports

One of the practices in this process is the involvement of natural supports on the family's child and family team. Natural supports of the family might include: extended family, friends, neighbors, clergy, or colleagues.

A healthy balance should be approximately: 25% formal services and supports (interventions that cost money), and 75% natural supports (things that do not cost money).

Natural systems may also contribute "hard goods" such as clothing or a bicycle, or emergency financial support when families have such needs.

The faith community is an important natural partner in supporting families in the process.



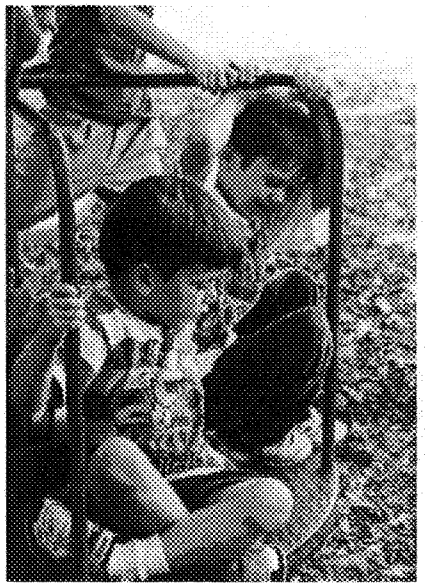
KIDS IN DISTRESS

Social Networks and Informal Supports

People are supported through community and family social networks and informal community resources. To avoid dependency on systems, services and supports focus on building and strengthening social networks and natural supports of family, **friends**, and **community resources** for children and families. (Teachers, social workers, clergy, therapists, and others identified by the family as important sources or potential sources of support.)

Some families who have lost their natural supports may only have professionals initially. When composed mostly of professionals, one of the professional's goal is to increase the family support system size and recruit more natural supports over time.

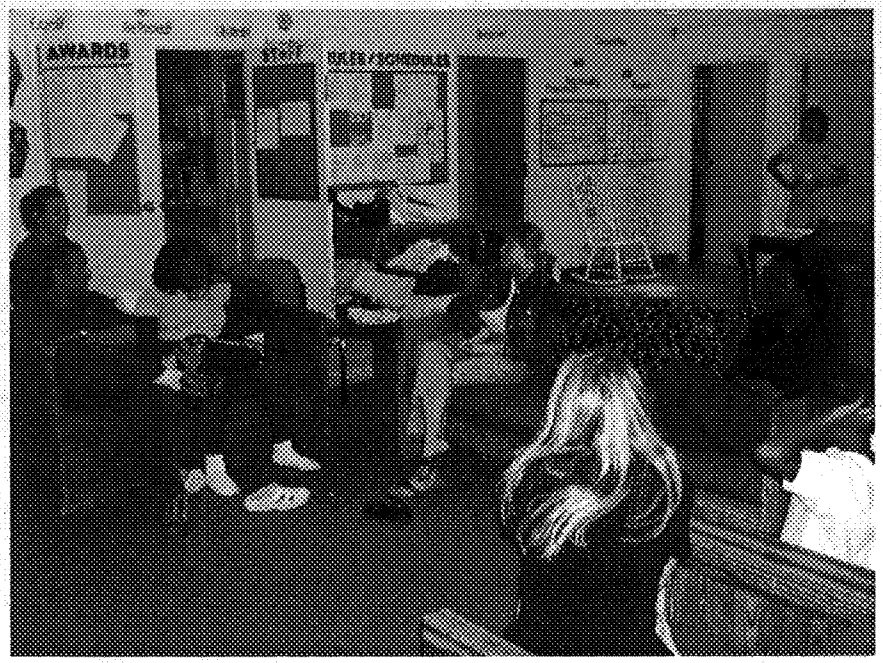
Failure to successfully engage a family will ensure a failure of the process.



KIDS IN DISTRESS

Collaboration and Community Support

Collaboration between agencies, schools, community resources (e.g. service organizations, church, and business) and families is the best way to build effective services and supports for children and families with complex needs.



Wherever the needs of children and families go beyond what any one entity can provide, professionals from various agencies, schools and the community come together to meet these needs. In addition, these entities engage in ongoing strategic planning to improve the System of Care.

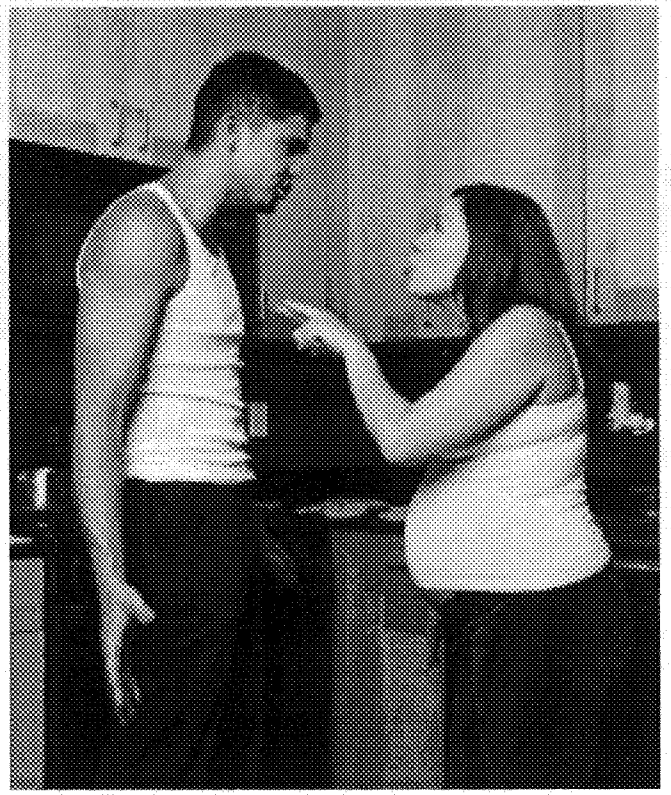
KIDS IN DISTRESS

Family Preservation

KID Family Preservation engages the family and provides in-home services and case management support to families with allegations of abuse and neglect who are at risk of having their children removed from their homes. The Program will also provide reunification and support services to children returning home, and to their families, relative caregivers or adoptive placements.

Domestic Violence

The Glass House provides a comprehensive Family Violence Program providing a psycho educational approach that promotes responsibility for violent behavior and the development of mechanisms for self-regulation, empathy or compassion for others, and appropriate vocabulary to express intimacy (for perpetrators), and self improvement and coping skills (for victims). Services includes: Batterer's Intervention, Victim Support, Anger Management, and Services for Children Exposed to Domestic Violence

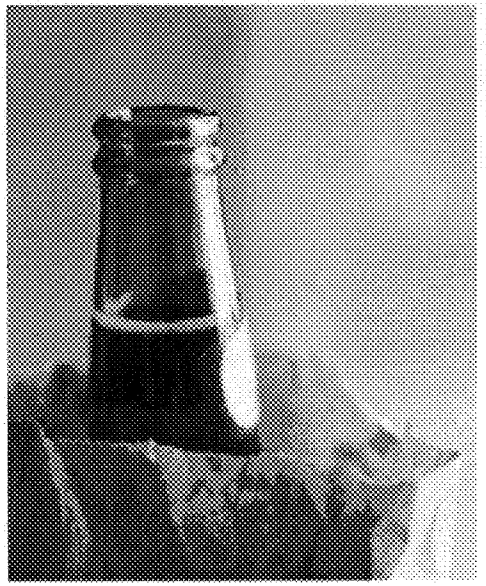


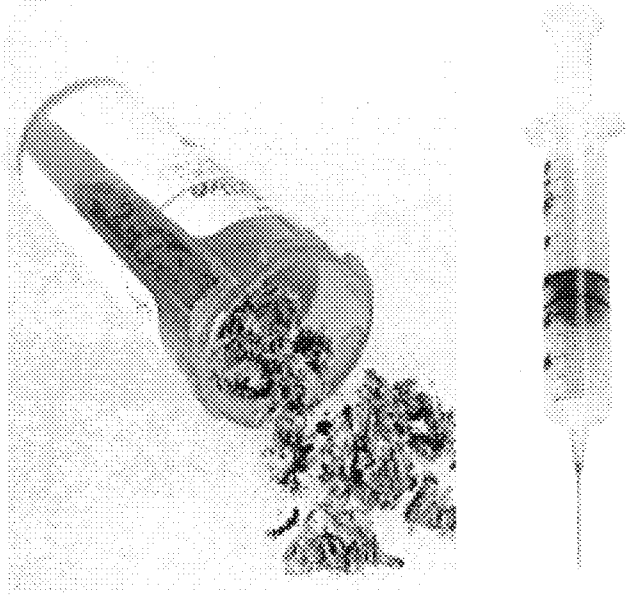
KID also partners with Women In Distress, who provides shelter services to Victims. KID provides service to children and ongoing transitional support to families working on independence.

KIDS IN DISTRESS

Substance Abuse Counseling

Broward Addiction Recovery Center (BARC) is the largest community-based substance abuse provider in Broward County, providing multiple evaluation and treatment services to adults (parents). Substance Abuse therapists provide evaluation, treatment, and relapse prevention services, urinalysis screens, and access to more in-depth substance abuse treatment at their residential and day-treatment facilities.





Parenting

The Mental Health Association of Broward County (MHA) provides court ordered parenting skills training (PEPS) to clients, with program tracks including discipline vs. punishment, anger management, child development and age appropriate behaviors, parent-child communication, self-esteem, stress management, empathy and positive discipline techniques as alternatives to corporal punishment, and role playing, and modeling of appropriate parental behavior.

KIDS IN DISTRESS

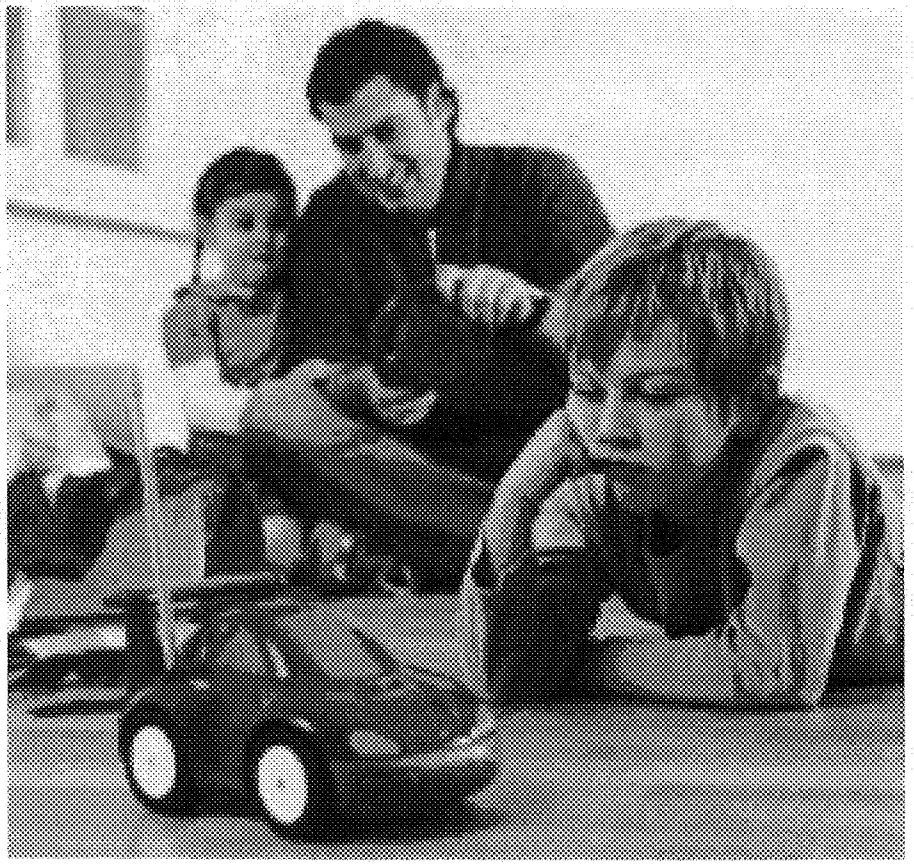
Behavioral Health / Therapeutic Services

The Kids In Distress Family Counseling Clinic Provides:

Clinical (Behavioral Health) and assessment services that are designed to meet the individual needs of children and their families, without regard to race, gender, religion, ethnic background, socio-economic status or political affiliation. Services are designed to recognize socio-cultural values, personal and family goals, life style differences and the complex interactions within the family.

Services are provided by a professional, credentialed team specifically trained in the field of abuse and neglect, attachment and bonding, early childhood development, infant mental health, the effects of foster care and adoption, and family systems.

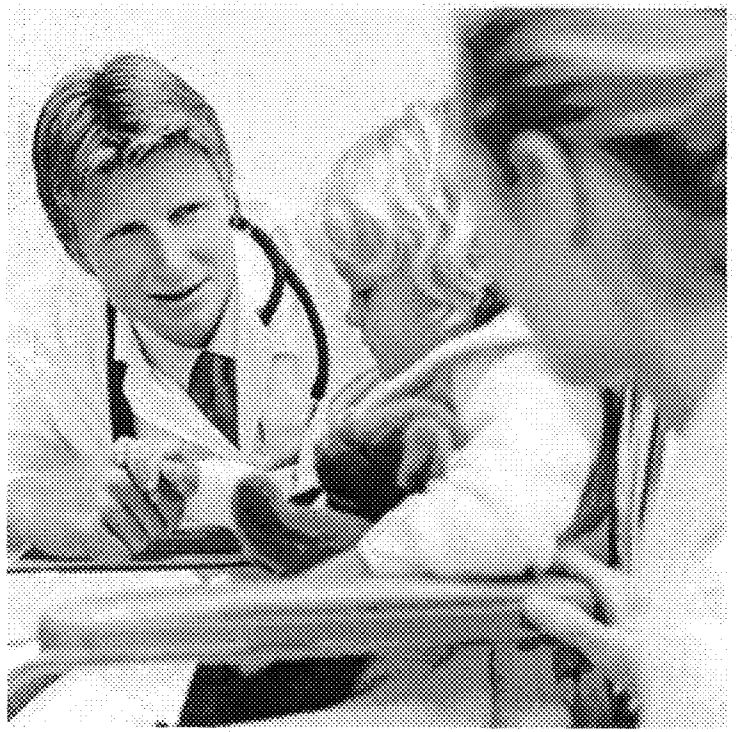
Supervised Visitation



Families ordered by the Dependency and Family Courts in the 17th Circuit are provided with 8 weeks of supervised visits, therapeutic (enhanced) visitations and/or monitored exchanges. Services are provided in 3 convenient locations in the North, Central and South areas of Broward County, by Kids In Distress.

KIDS IN DISTRESS

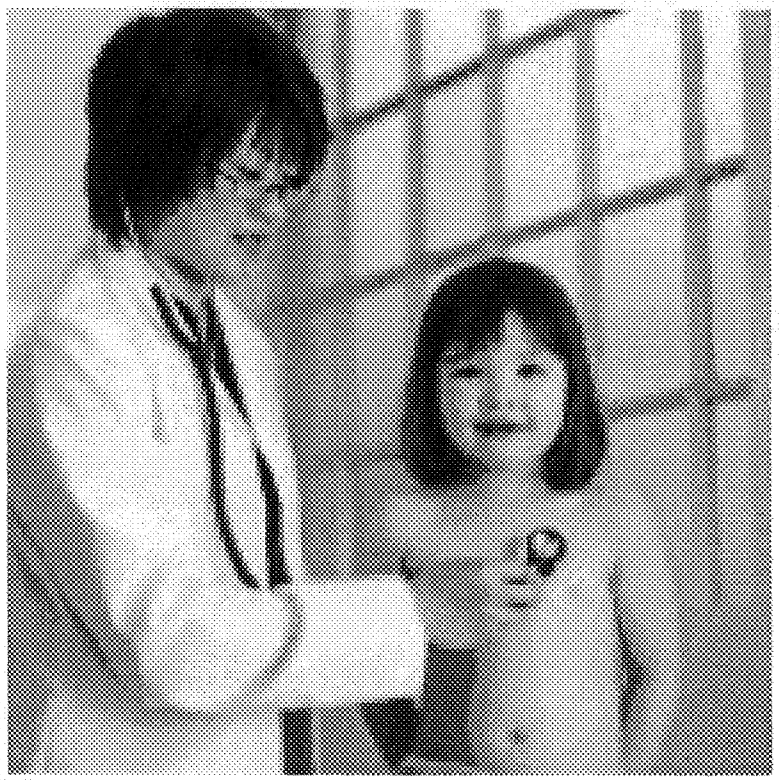
Medical Care



All medical services for children who reside on the Kids In Distress Campus, are provided by Children's Diagnostic and Treatment Center (CDTC).

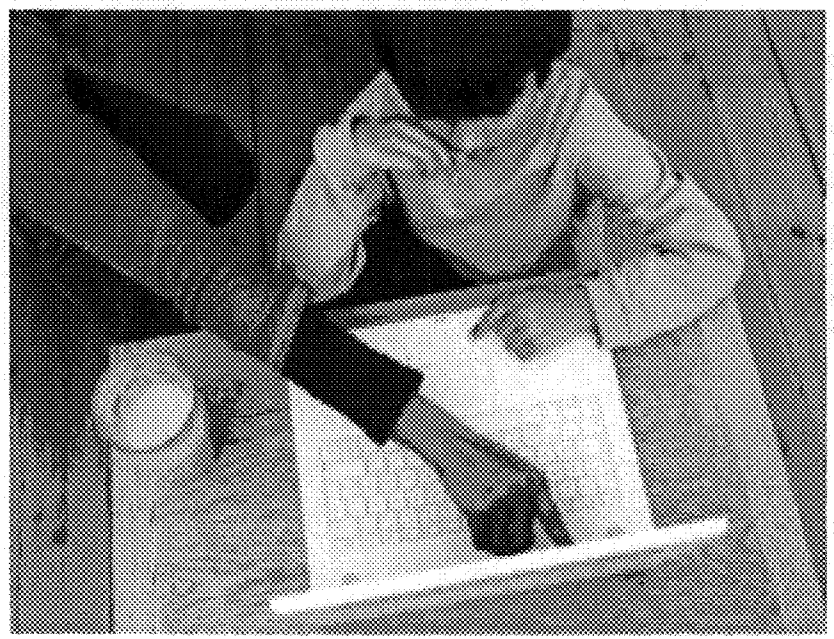
CDTC sends a doctor to see the children who reside in the Kids In Distress group homes and shelters. When more specialized services are needed children are seen at CDTC immediately or the CDTC physician makes the necessary specialized referral. CDTC medical social workers assist in navigating the medical system whenever necessary and works with collaboratively with the Kids In Distress Nurse.

KIDS IN DISTRESS



The Broward Children's Center (BCC) sends a medical van to the KID preschools and to organized KID family events in the community, so that families unable to access medical care and immunizations for their children are provided with this necessary care.

Other Therapies



Therapeds provides Occupational Therapy, Speech Therapy, and Physical Therapy to the children served at KID. These professionals work in partnership with the KID staff to ensure that all treatments, therapies and services are coordinated effectively and appropriately.

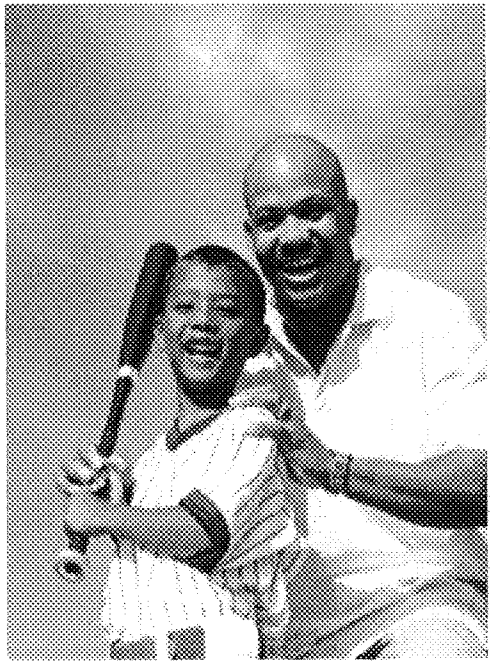
KID is also a contracted Healthy Families and Healthy Start Provider. Once a family is identified through either of these services and are in need of additional services provided by the KID collaborative, an "internal" KID referral is made.

The uniqueness of this collaborative is the "one-stop-shop" that families experience. Most often families are referred to multiple service providers to meet their diverse needs. This model brings the services together for a family. The family becomes a primary client to ALL the providers and experience a seamless system of care.

KIDS IN DISTRESS

Supports in Communities Include

- Faith community
- Service clubs (Kiwanis, Elks, Masonic Temples, Optimists, Daughters of the American Revolution, Etc.)
- Community centers and organizations (Jewish Community Centers, YMCA, Urban League, etc.)
- Veterans clubs or groups (Veterans of Foreign Wars, etc.)
- Business groups (professional organizations, chamber of commerce)
- Ethnic clubs (Italian club)
- Senior organizations and centers
- And dozens of others



Referral Sources (FY 05-06)

- More than 600 Families were referred by Broward Sheriff's Office Child Protection Investigation Section.
- 2nd most referrals came from ChildNet, the lead agency in Broward County.
- 3rd were self referred.
- 4th were families were referred by other Community Based Care Providers and Community Agencies.
- Some families were referred by The Department of Children and Families.
- A few Cases were referred by Broward County Schools.

KIDS IN DISTRESS

Total Number of Families and Children Served (FY 04/05)

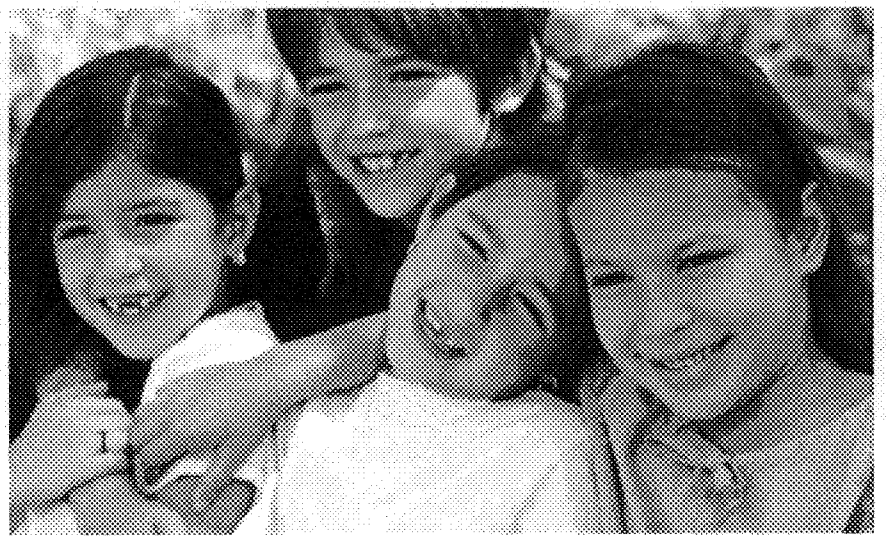
- **993** Families, 1957 Children Served
- 80% received two or more services
- The CFS Program serves between 225 and 240 Families at any given time.

Ethnicity

- 56% African American
- 32% White American
- 8% Hispanic
- 1% Haitian
- 1% Biracial
- 1% Native American
- 1% Other

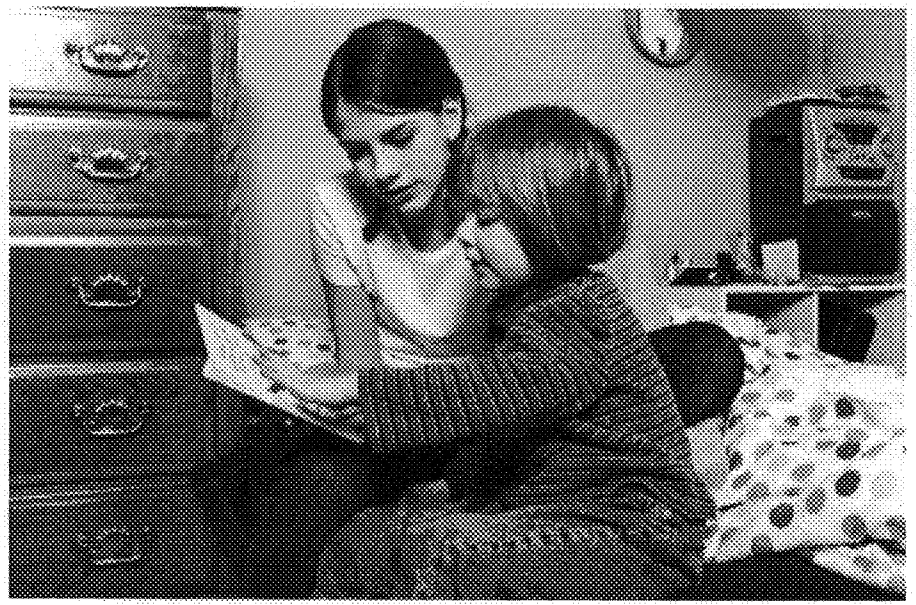
Statistics and Outcomes

- **100%** of families served had children safely maintained in their own homes whenever possible and appropriate.
- **99%** of eligible families served had no verified findings of abuse or neglect within six months of case closure.
- **99%** of eligible families served have achieved permanency and stability in their living conditions.
- **98%** of families served had a psychosocial assessment completed within the first seven days of accepting services.
- **99%** of families served had a preservation plan completed within fourteen days of accepting services.



- **100%** of eligible families served continued to be linked to services after discharge and during follow-up surveys.
- **98%** of children who were enrolled in the Family Intervention program for twelve or more weeks demonstrated an improved child well being score from pre-test to post-test.

KIDS IN DISTRESS



- **83%** of families served successfully completed the Coordinated Family Services program and treatment plan goals for substance abuse, domestic violence, and or parenting skills intervention.
- **81%** of families served demonstrated increased knowledge of child development and behavior.
- **77%** of families served report a reduction in stress and improved family communication.
- **87%** of families served demonstrate healthier, less abusive parental attitudes and behaviors.
- **86%** of clients enrolled in the Substance Abuse Intervention program (B.A.R.C.) were substance free while in the program.
- **80%** of clients enrolled in Domestic Violence Treatment program (GlassHouse) completed the program and demonstrated increased knowledge of domestic violence and its effects.
- **91%** of clients enrolled in the Domestic Violence Treatment program (GlassHouse) had no subsequent incidences of domestic violence while in the program.

KIDS IN DISTRESS

Additional Facts

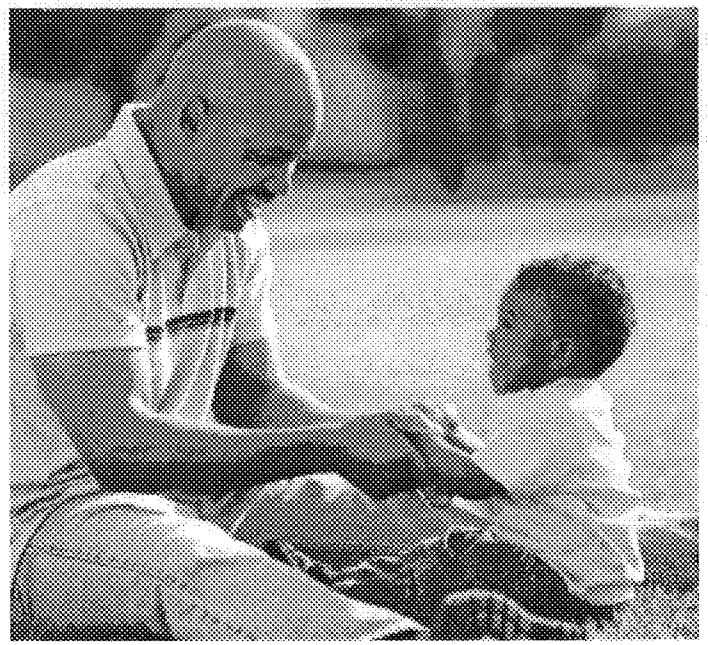
By assessing the data on the previous pages, and using approximates, it is estimated that 90% of the families were referred by BSO/CPIS (representing in-home services), that did not require a petition resulting in adjudication dependent (i.e. the children were not removed from the custody of their parents).

The referrals from The Department of Children and Families, as well as the Community Based Providers would represent 50% (VPS/PS/in-home) and 50% out of home care.

KIDS IN DISTRESS

Costs

The cost of providing solely in-home KID FIRST services to a family is a one time cost of approximately $1500 per family, or $600 per child. The cost increases as families access more of the clinical services that may be required to meet their needs.



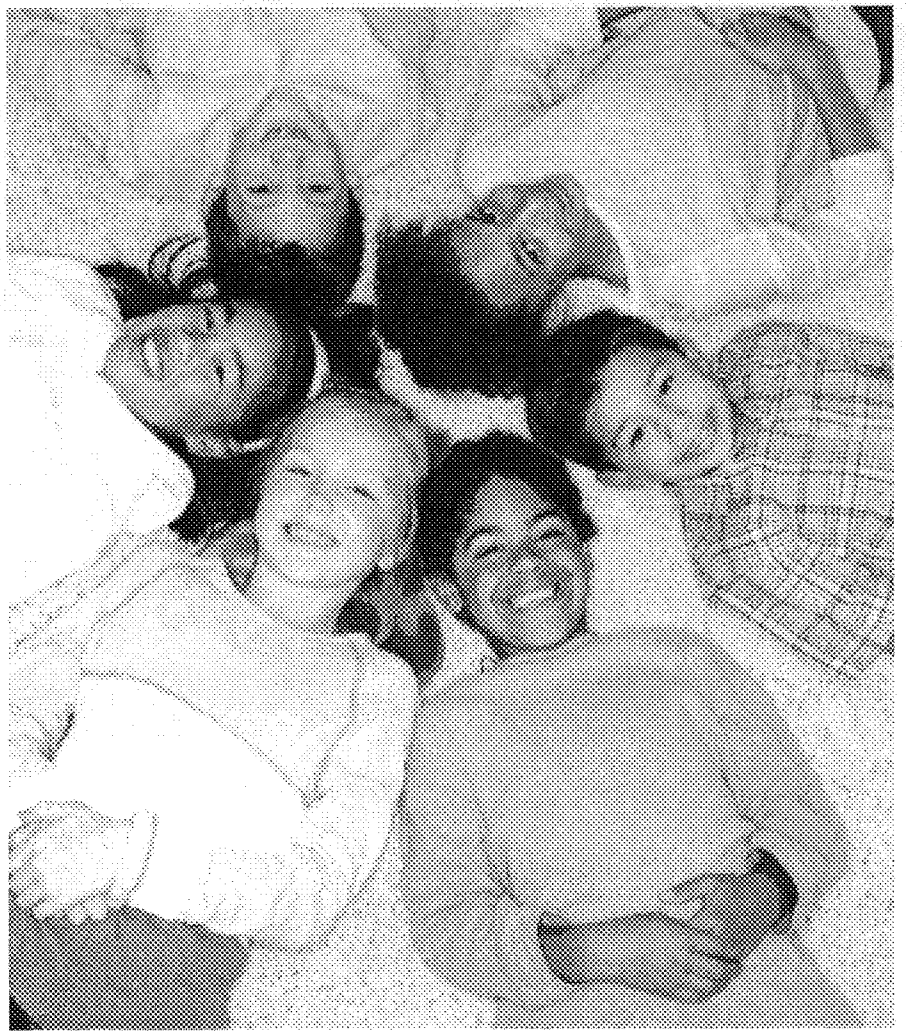
Substance Abuse/Domestic Violence/and Behavioral Health Services costs are approximately $69 per professional hour. Parent Training cost is approximately $50 an hour.

An adult could receive anywhere from 1 hour a week to 3 or 4 hours per week depending on their individualized case plan. The exact clinical costs per person is unavailable at this time.

KIDS IN DISTRESS

Current Challenges

- **Psychiatric services** for parents (huge need).
- **Therapeutic/Clinical services**
- **Affordable housing** (huge need).
- **Ongoing Mentoring for children and families** (huge need).



KIDS IN DISTRESS

KIDS IN DISTRESS

Holly Hills, Ph.D.

The Impact of Substance Use Disorders On Women Involved in Dependency Court†

Holly A. Hills, Ph.D.*
Deborah Rugs, Ph.D.**
M. Scott Young, M.A., M.S.***

INTRODUCTION

Women are entering substance abuse treatment in increasing numbers and, often, come to treatment as the result of their involvement in dependency court.[1] Unfortunately, traditional substance abuse treatment models are not designed to address women with children and multiple vulnerabilities. Part I of this Article reviews the literature and data discussing the relationship between child abuse and neglect and substance abuse. Part II identifies referral pathways through which women enter substance abuse treatment, focusing on the referral process in the Hillsborough County, Florida dependency courts. Part III describes the role of dependency courts in encouraging compliance with substance abuse treatment recommendations. Part IV identifies innovative substance abuse treatment models that address women and their children. Part V describes the methodology and findings of key informant interviews and file reviews, which were conducted to uncover the complex

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† Editor's Note: Many of the assertions in this Article are based on the observations and experiences of the authors. *The Journal* disclaims responsibility for any factual inaccuracies contained herein.

* Associate Professor, Dep't of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida.

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*** Coordinator of Statistical Research, Dep't of Mental Health, Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida.

1. Holly A. Hills et al., Understanding the Impact of Substance Abuse on Families Involved in Child Welfare, report to the Children's Board of Hillsborough County, Florida (2002) (unpublished manuscript, on file with authors).

issues associated with women involved in substance abuse treatment as a result of abuse or neglect charges. Finally, Part VI provides recommendations to better address the substance use disorders of women involved in dependency court.

I. OVERVIEW OF LITERATURE AND DATA

A. Rates of Child Abuse and Neglect

Child abuse and neglect is not uncommon and can have fatal consequences. Many children are placed in out-of-home care during their critical developmental years because of maltreatment. From 1986 to 1997, the number of abused and neglected children in the United States jumped from 1.4 million to 3 million, a rise of more than eight times the increase in the child population.[2] The Child Welfare League of America reported that in 2000, there were 1,137 child abuse and neglect fatalities nationally.[3] Of these fatalities, only a minority, 527 (46%), had no verified prior involvement with a child welfare agency.[4] As of September 30, 2000, 547,415 American children lived in out-of-home care.[5] Many of these children had already entered, exited, and reentered out-of-home care in the past year.[6]

Florida's child abuse and neglect data is consistent with national data, as it indicates that child maltreatment is widespread, and may have fatal consequences. Between 1995 and 2000, the total number of

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2. The number of abused and neglected children rose 114.3% compared to a 13.9% increase in child population. NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA U., NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS (1999) [hereinafter CASA]. In all instances, the data presented represents the most recent data available.

3. Child Welfare League of Am. Nat'l Data Analysis Sys., Number of Child Abuse and Neglect Fatalities, by History with the Child Welfare System (CWLA Survey), 2000, *at* http://ndas.cwla.org/Report.asp (last visited Sept. 29, 2003) (on file with the Washington University Journal of Law & Policy).

4. *Id.*

5. Child Welfare League of America Nat'l Data Analysis Sys., Number of Children in Out-of-Home Care, 1998-2000, *at* http://ndas.cwla.org/Report.asp (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

6. Child Welfare League of America Nat'l. Data Analysis Sys., *at* http://ndas.cwla.org/pretoc.asp (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

children in Florida's foster care system increased 43%, while the number of children entering Florida's system for the first time increased 77%.[7] Additionally, the number of children reentering Florida's foster care system increased 191% between 1990 and 2000.[8] In 2000, sixty-five children in Florida died as a direct result of abuse and/or neglect.[9] Of these, twenty-one had previous involvement with a child welfare agency.[10]

Recently, Hillsborough County, Florida, has undertaken investigations to examine child maltreatment and parental substance abuse. In 1997, 13,444 Hillsborough County children were alleged victims of child abuse and/or neglect.[11] The Department of Children and Families substantiated 6,003 of these allegations.[12] Of those 6,003 abused or neglected children, only 2,411 received some form of intervention.[13]

B. The Relationship Between Parental Substance Abuse and Child Abuse and Neglect

The relationship between parental substance abuse and child maltreatment is well-documented. Studies suggest that chemical dependence exists in at least half of the families involved with the public child welfare system.[14] Alcohol and drug abuse is "a

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7. Eric C. Brown et al., U. of S. Fla., Louis de la Parte Fla. Mental Health Inst., Dep't of Child and Fam. Stud., Measuring the Length of Stay Experiences of Florida's Foster Children xi (2001), *available at* http://cfs.fmhi.usf.edu/stateandlocal/ consortium/publications.html (last visited Oct. 3, 2003) (on file with the Washington University Journal of Law & Policy).

8. *Id.* at 18.

9. Child Welfare League of Am. Nat'l Data Analysis Sys., Number of Child Abuse and Neglect Fatalities, by History with the Child Welfare System (CWLA Survey), 2000, *at* http://ndas.cwla.org/Report.asp (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

10. *Id.*

11. Beth A. Barrett et al., U. of S. Fla., Louis de la Parte Fla. Mental Health Inst. Dep't of Child and Fam. Stud., Hillsborough County Child Protection Study 5 (March, 1999) (unpublished manuscript on file with authors).

12. *Id.*

13. *Id.* Data indicates that 1,462 children received protective supervision, 270 children were placed in foster care, 85 children were adopted, and 594 children were placed in other out-of-home interim placements. *Id.*

14. J. Michael Murphy et al., *Substance Abuse and Serious Child Mistreatment: Prevalence, Risk, and Outcome in a Court Sample,* 15(3) CHILD ABUSE & NEGLECT 197 (1991). However, this is considered a conservative estimate, as other studies have found rates as

significant contributing factor" in 60% to 90% of cases referred to juvenile and family courts.[15] Alcohol and drug abuse are factors in more than 65% of cases where children are placed in foster care.[16] Individuals working within the child welfare field indicate that the main reason for skyrocketing protective services caseloads is an increase in parental substance abuse, particularly crack cocaine.[17]

Numerous research investigations also document the impact of parental substance abuse on children's care. Compared to a matched control community sample of parents, adults with an alcohol or drug disorders are 2.7 times more likely to report their abusive behavior and 4.2 times more likely to report their neglectful behavior toward their children.[18] Another investigation found that parents with substance abuse histories are significantly more likely than other parents: (a) to be repeat child abuse or neglect offenders; (b) to be rated by court investigators as presenting a high risk to their children; (c) to reject court-ordered services; and (d) to have their children permanently removed.[19] Additionally, research shows that children removed from the home due to parental substance abuse fare worse than children who were removed for other reasons. For example, children, particularly minority children, in out-of-home placement due to parental substance abuse are less likely to return to their biological parents, and are less likely to be adopted.[20] Children of

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high as 80% to 90%. *See* LAURA FEIG, U.S. DEP'T OF HEALTH AND HUM. SERVICES, DRUG-EXPOSED INFANTS AND CHILDREN: SERVICE NEEDS AND POLICY QUESTIONS (1990); Kelly Kelleher et al., *Alcohol and Drug Disorders Among Physically Abusive and Neglectful Parents in a Community Based Sample*, 84 AM. J. PUB. HEALTH 1586, 1588 (1999).

15. National Council of Juvenile and Family Court Judges, Alcohol and Other Drugs Division (2001), *at* http://ncjfcj.unr.edu/homepage/drugs.html (last visited Aug. 6, 2001).

16. CHILD WELFARE LEAGUE OF AMERICA, FAMILY FOSTER CARE FACT SHEET (2000), *at* http://www.cwla.org/programs/fostercare/factsheet.htm (last visited Oct. 20, 2003) (on file with the Washington University Journal of Law & Policy).

17. Patrick A. Curtis & Charlotte McCullough, *The Impact of Alcohol and Other Drugs on the Child Welfare System*, 72 CHILD WELFARE 535, 536 (1993). *See also* CASA, *supra* note 2.

18. Kelleher et al., *supra* note 14, at 1588.

19. Murphy et al., *supra* note 14.

20. Douglas J. Besharov, *Crack Children in Foster Care: Re-examining the Balance between Children's Rights and Parent's Rights*, 19 CHILD. TODAY 21, 24 (1990); *see also* David Fanshel, *Parental Failure and Consequences for Children: The Drug-Abusing Mother Whose Children Are in Foster Care*, 65 AM. J. PUB. HEALTH 604, 606, 607 tbl. 2 (1975); FEIG, *supra* note 14; NAT'L BLACK CHILD DEV. INST., WHO WILL CARE WHEN PARENTS CAN'T: A

drug-abusing mothers also remain in foster care for longer periods of time, and experience more foster care placements than children who were removed for other reasons.[21]

Given the relationship between parental substance abuse and child abuse and neglect, parental substance use disorder treatment appears crucial to the welfare of substance-abusing mothers and their children. However, the process through which women involved in dependency court find their way into drug treatment varies.

II. REFERRAL PATHWAYS THROUGH WHICH WOMEN ENTER SUBSTANCE ABUSE TREATMENT

Women enter substance abuse treatment through a variety of paths, but, increasingly, they begin treatment because of a court's recommendation in a child abuse or neglect case. Women entering the dependency court process in Hillsborough County, Florida often experience a common sequence of events.[22] First, an abuse or neglect report is called into the hotline. Then, an investigator goes to the address, assesses the report, and makes a determination as to whether the child(ren) should be removed from the parent's custody. At that time, depending on the initial report, the investigator may or may not assess whether substance abuse is a contributing factor in the removal decision. Within twenty-four hours of the investigator's visit, the court holds a hearing, which typically supports the investigator's removal recommendation. After the hearing, the child is officially placed with the father, another relative, or in foster care. Within thirty days, the court schedules a hearing to review elements of the case plan that address the conditions associated with the abuse or neglect.

Awareness of a custodial parent's substance abuse history or evidence that substance abuse may have played a role in instigating the initial report may result in a treatment evaluation

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STUDY OF BLACK CHILDREN IN FOSTER CARE (1989); CLARICE WALKER ET AL., NAT'L BLACK CHILD DEV. INST., PARENTAL DRUG ABUSE AND AFRICAN AMERICAN CHILDREN IN FOSTER CARE: ISSUES AND STUDY FINDINGS (1991).

21. Fanshel, *supra* note 20, at 606.

22. Information in this timeline was collected through a series of key informant and workgroup interviews conducted by the first author (H. Hills) between October, 2001 and April, 2002. Findings were reported and validated by community workgroup participants.

recommendation. While mothers may initiate that evaluation after the initial hearing, many wait until it appears as a requirement of their formal case plan. Typically, a mother can obtain a treatment evaluation within seven days of a request, however, she often has to pay for it. If the evaluation recommends that the mother participate in treatment, this will be transmitted to the Department of Children and Families (DCF) Child Protective Services caseworkers. The recommendation for treatment may or may not become part of the dependency court case plan that DCF presents to the judge.

If the recommendation is incorporated into the official case plan, it routinely takes at least five months from the date of the initial abuse or neglect report for the mother to initiate treatment, due to procedural and other legal elements of the process. As elements of the case plan are implemented, the case continues to move through the dependency court process. The mother returns to court approximately every three months, while her children remain in foster care.[23] The court may not require mothers to remain in treatment as a condition of reunification, even if substance abuse was an important factor in the initial abuse or neglect report and a treatment recommendation is part of the case plan.

Based on this sequence of events, one can reasonably infer that many elements of the standard process do not support effective transitions into substance abuse treatment, do not help maintain treatment, and do not work to facilitate prompt and successful reunification.

III. THE ROLE OF DEPENDENCY COURT ACTIONS IN ENCOURAGING COMPLIANCE WITH TREATMENT RECOMMENDATIONS

Issues associated with the protracted delays in completing dependency court requirements lead to children becoming stuck in foster care "limbo"—unable to return to their mothers and unavailable for adoption. Society began to view this limbo as extremely deleterious to children.[24] As a result, advocates began to

23. Non-relative placements allow for only one hour-long visit per week, and scheduling conflicts for both parties often lead to cancellations.

24. THE NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA

encourage the legal process to consider this deleterious impact.[25] This effort began in the early 1990s, and led Congress to enact federal legislation that recognizes how important each year is in a child's life, and that being in a stable family setting is integral to children's long-term mental health.[26]

A. Child Welfare Reform

To push for earlier and more decisive permanency hearings, Congress passed the Adoption and Safe Families Act of 1997 (ASFA).[27] In place of the previous requirement to hold a "dispositional" hearing within eighteen months after placing a child in foster care, the Act renamed the hearing a "permanency" hearing.[28] It also requires the hearing to include a decision whether to return the child home, initiate termination proceedings, or place the child in another permanent living arrangement.[29] Furthermore, the Act requires that the hearing take place within twelve months of the child's original placement.[30]

B. Issues that Impact Reunification with Children Placed in Out-of-Home Care

Although ASFA makes clear that children have the right to be reunified with their families or made available for adoption, the Act does not articulate what specific efforts must be made to support parents and encourage reunification; it only, vaguely, states that child

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UNIVERSITY, NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS (Jan. 1999) (unpublished manuscript on file with authors).

25. Barrett et al., *supra* note 11, at 6.

26. The Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.). The Act sought to decrease the amount of time children languish in foster care by encouraging states to streamline their permanency processes.

27. *Id.*

28. *Id.* at 2128.

29. *Id.* at 2116.

30. The twelve-month period does not begin to run from the time of the child's actual removal, but from either a judicial finding of abuse or neglect or sixty days after the child's removal from the home, whichever comes earlier. This period begins to run at the same time as the fifteen-month period for initiating termination of parental right. *Id.* at 2119.

welfare agencies must make "reasonable efforts."[31] For parents struggling with addictions, significant coordination across numerous social services will be necessary to create a suitable environment for reunification. Despite data that associates substance use disorders with 40% to 80% of all abuse and neglect cases,[32] most state child welfare offices do not make it standard procedure to ensure that parents receive treatment for their substance use disorders. In the CASA survey, 42% of caseworkers said they were not required to determine if substance abuse is present when investigating child maltreatment.[33] For parents who have substance abuse problems, there is limited evidence that they receive referral or treatment in a timely fashion, if at all, to prevent the termination of their parental rights.[34] In our own survey of DCF caseworkers in the Tampa Bay area, we found that among the thirty programs to which DCF caseworkers most commonly referred their clients, only four provided substance abuse treatment.[35]

C. Innovations in Assessment of Substance Abuse in Child Welfare Families

In response to ASFA, DCF implemented a Child Safety Assessment.[36] Its purpose is "to assure thorough assessment and provision of child safety and determine the disposition of investigation of report."[37] The assessment is part of Florida's new child welfare information system, called HomeSafenet.[38] The critical components of the new system are: tools to transfer information

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31. *Id.* at 2116.

32. Child Welfare League of America, Alcohol and other drug fact sheet (2001), *available at* http://www.cwla.org/advocacy/aodfactsheet.htm.

33. CASA, *supra* note 2, at 31.

34. *See, e.g.*, CHILD WELFARE LEAGUE OF AMERICA, ALCOHOL AND OTHER DRUG SURVEY OF STATE CHILD WELFARE AGENCIES (1998); CASA, *supra* note 2.

35. Hills et al., *supra* note 1.

36. FLORIDA GOV'T, DEP'T CHILDREN & FAMILIES, CHILD SAFETY ASSESSMENT (r19.vsd. Feb. 2001).

37. *Id.*

38. After initial testing and a review of the Child Safety Assessment's psychometric properties, Florida will add other important improvements to the child welfare system. THE FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES SERVICES, PROGRESS REPORT FOR THE GOVERNOR'S BLUE RIBBON PANEL ON CHILDREN PROTECTION (2003).

needed for planning services; accountability for ongoing services; a case plan summary; monitoring of case plan progress; and systematic data collection on caregiver substance use.[39]

Significantly, the Child Safety Assessment includes several questions related to parental use and abuse of drugs and alcohol.[40] The inclusion of these items and the potential data that will be derived from them are important steps in providing substance abuse treatment to families in need. These questions should encourage evaluations for substance use disorders in all protective investigations and acknowledge the integral role substance use disorders play in child abuse and neglect complaints.

D. Innovations in Judicial Action: Family Drug Courts

Part of the solution to connecting parents to the services they need lies in improving assessments, referrals, engagement strategies, and perhaps, developing and implementing family drug courts. A family drug court is:

> a drug court that deals with cases involving parental rights in which an adult is the party litigant, which comes before the court through either the criminal or civil process, and which arise out of the substance abuse of a parent, and include custody and visitation disputes; abuse, neglect, and dependency matters; petitions to terminate parental rights; guardianship proceedings; or other loss, restriction, or limitation of parental rights.[41]

The purpose of family drug (or drug treatment) court is to improve the way courts handle child abuse and neglect cases that involve a parent with a substance use disorder. An additional reason for

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39. *Id.*

40. CHILD SAFETY ASSESSMENT, *supra* note 36. Specific questions that address alcohol and drug abuse include: Does the child or adolescent exhibit behavior(s) that may be indicative of abuse or neglect? Included in this list is reference to the child's alcohol or drug use. Does the caregiver's drug or alcohol use affect his or her ability to adequately care for child(ren)? Do the child(ren) live in a crack house or similar environment? *Id.*

41. CAROLINE S. COOPER & SHANIE BARTLETT, OFF. OF JUST. PROGRAMS: DRUG COURT CLEARINGHOUSE AND TECH. ASSISTANCE AT AM. U., JUVENILE AND FAMILY DRUG COURTS: PROFILE OF PROGRAM CHARACTERISTICS AND IMPLEMENTATION ISSUES (1998).

creating family drug courts is to facilitate compliance with ASFA.

Key components of a family drug court are: (1) screening and assessment; (2) use of a non-adversarial approach; (3) a continuum of alcohol and drug treatment with accompanying wraparound rehabilitative and logistic services that support families and recovery; and (4) alcohol and other drug testing.[42] Additionally, the judge, treatment personnel, and an integrated case manager are considered essential members of a professional team who closely monitor participants' compliance with treatment through a system of rewards and sanctions.[43]

Family drug courts are developed primarily when a jurisdiction has an ongoing adult and, typically, juvenile drug court. The development of juvenile and family drug court programs is considered "extremely complex and considerably more difficult than adult drug court development" due to the difficult issues and potential number of parties involved.[44] Typically, family drug court initiatives are initiated by a judge with experience in juvenile or adult drug court, an interest in family law, and an interest in reducing the number of children entering the foster care system.[45] Usually, the judge will take it upon himself or herself to convince county funding agencies to back the program, and will get social service agencies, such as treatment providers, to commit funding to the program.

Currently, approximately twenty jurisdictions in ten states have family drug court programs.[46] Some of the earliest and best known programs are in Reno, Nevada; Escambia County, Florida; Miami, Florida; Las Vegas, Nevada; and New York, New York.[47] The Center for Substance Abuse Treatment is conducting an outcome study on the effectiveness of family drug courts.

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42. Charles M. McGee, *Family Drug Court: Another Permanency Perspective*, 48 JUV. & FAM. CT. J. 65, 65-67 (1997).

43. *Id.*

44. COOPER & BARTLETT, *supra* note 41, at I.C.

45. McGee, *supra* note 42, at 65-67.

46. Sharon G. Elstein, *Family Drug Courts May Hold the Key for Abused and Neglected Children of Substance Abusers*, 18 A.B.A. CHILD L. PRAC. 1, 6 (1999).

47. *Id.* Courts and treatment professionals in Hillsborough County, Florida, are currently developing a family drug court. They have recently traveled to an organizational conference and completed site visits to Pensacola, Florida and Reno, Nevada to evaluate the models employed and to determine how to import these characteristics into the local community.

IV. INNOVATIVE MODELS OF SUBSTANCE ABUSE TREATMENT FOR WOMEN AND THEIR CHILDREN

The vast majority of substance abuse treatment programs were designed to serve male clients, not to address the special issues that mothers with dependent children present.[48] Around the country, programs have been and are being developed that are tailored specifically to assist mothers with substance use disorders. The most promising programs offer services for both mothers and their children, recognizing that treatment must embrace the parental role.[49] While some of these programs are residential and allow children to live with their mothers, some outpatient programs offer a form of child care so mothers can attend treatment sessions.[50]

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48. Child Welfare League of America, Alcohol and other Drugs Fact Sheet (2001), *available at* http://www.cwla.org/advocacy/aodfactsheet.htm.

49. Kathleen Wobie et al., *Women and Children in Residential Treatment: Outcomes for Mothers and Their Infants*, 27 J. DRUG ISSUES 585-606 (1997); Shirley D. Coletti et al., *Specialized Therapeutic Community Treatment for Chemically Dependent Women and Their Children*, *in* COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS 115-28 (George De Leon ed., 1997); P. Hughes et al., *Retaining Cocaine-Abusing Women in a Therapeutic Community: The Effect of a Child Live-in Program*, 85 AM. J. PUB. HEALTH 1149-52 (1995); Cheryl Zlotnick et al., *The Impact of Outpatient Drug Services on Abstinence Among Pregnant and Parenting Women*, 13 J. SUBSTANCE ABUSE TREATMENT 195 (1996).

50. Typically, programs offer the following services: on-site childcare; parenting and child care skills classes; play groups; child development classes; prevention services for children under eighteen; family services; sexual abuse and domestic violence support groups exclusively for women; GED classes; job preparation; on-the-job training; prenatal care; nutritional counseling; health education; pediatric exams; comprehensive psychological and developmental assessments; transportation; and health care. Examples of these programs can be found in the following references: L. Metsch et al., *Implementation of a Family-Centered Treatment Program for Substance-Abusing Women and Their Children: Barriers and Resolutions*, 27 J. PSYCHOACTIVE DRUGS 73-83 (1995); Zlotnick et al., *supra* note 49; A. Carten, *Mothers in Recovery: Rebuilding Families in the Aftermath of Addiction*, 41 SOCIAL WORK 214-23 (1996); J. Camp & N. Finkelstein, *Parenting Training for Women in Residential Substance Abuse Treatment: Results of a Demonstration Project*, 14 J. SUBSTANCE ABUSE TREATMENT 411-22 (1997); M. Kaplan-Sanoff & S. Lieb, *Model Intervention Programs for Mothers and Children Impacted by Substance Abuse*, 24 SCHOOL PSYCHOLOGY REV. 186-99 (1995); J. Falk, *Project Exodus: The Corrections Connection*, *in* CHILDREN IN FAMILIES AT RISK: MAINTAINING THE CONNECTIONS (L. Combrinck-Graham ed., 1995); F. Feinberg, *Substance Abusing Mothers and Their Children: Treatment for the Family*, *in* CHILDREN IN FAMILIES AT RISK: MAINTAINING THE CONNECTIONS (S. Stevens & N. Arbiter eds., 1995); C. Winick & J. Evans, *A Therapeutic community Program for Mothers and Their Children*, *in* ADDICTION AND PREGNANCY: EMPOWERING RECOVERY THROUGH PEER COUNSELING 143-59 (Barry R. Sherman ed., 1997); F. Suffet et al., *Pregnant Addicts in a Comprehensive Care*

Empirical data validating long-term outcomes for women's substance abuse treatment programs remains limited; most substance abuse treatment facilities designed for mothers are new and have not yet made their outcome data available in professional, peer-reviewed literature. Despite limited efficacy data, however, the tenet that mothers can be engaged and retained more successfully in treatment if they can bring their children with them has become an accepted conclusion. Though limited, data indicates that it is beneficial to include children early on in the design and implementation of a mother's substance abuse treatment. For instance, women stay in residential drug treatment significantly longer if they are permitted to have their children with them.[51] Additionally, the earlier a mother's child is permitted to reside with her at a substance abuse treatment facility, the longer she will remain in treatment.[52]

A. Program Descriptions and Outcomes

The substance abuse treatment programs for women and their children that have emerged over the past decade exemplify the diverse nature of the programs available to pregnant women and mothers. This section describes some of these programs and provides outcome data when available.[53]

The Coalition on Addiction, Pregnancy, and Parenting (CAPP), located in Boston, Massachusetts, is a twelve-month residential substance abuse treatment program in which mothers are allowed to live with their young children. Aside from receiving stable housing, parents also attend weekly parenting skills classes and child development groups. Aftercare services are provided once mothers complete the program, and these include individual counseling, home visits, and case management services. Published outcomes indicate that mothers enrolled in the parent skills classes demonstrated increased self-esteem, greater parenting knowledge, and better

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Program: Results of a Follow-up Survey, 51 AM. J. ORTHOPSYCHIARTY 297-306 (1981).

51. Patrick H. Hughes et al., *Retaining Cocaine-Abusing Women in a Therapeutic Community: The Effect of a Child Live-In Program*, 85 AM. J. PUB. HEALTH 1149, 1149-52 (1995).

52. Wobie et al., *supra* note 49, at 594.

53. For more detailed, tabular information, contact the authors.

parenting attitudes compared to mothers who were not enrolled in the parenting skills classes.[54]

PAR Village, located in St. Petersburg, Florida, is a model residential program.[55] The eighteen-month program contains an on-site licensed childcare facility.[56] In order to graduate, mothers must save $1,500 and arrange housing and childcare.[57] Approximately 80% of mothers who enter the program successfully complete treatment.[58]

Another program designed to assist substance abusing women is the Center of Chemical Addiction Recovery Efforts (CARE), located in the Center for the Vulnerable Child at Children's Hospital in Oakland, California.[59] This program offers services entirely free of charge and targets substance abusing mothers with infants and toddlers.[60] CARE indicates that 50% of mothers remain in treatment for five months, and those women who receive family services are four times more likely to remain abstinent for the first or second month of treatment.[61] The latter finding underscores the need to involve families in the treatment process.

Project Connect, located in Rhode Island, is considered another promising program.[62] The child welfare system identifies parents after a substantiated allegation of abuse or neglect, and program participation serves as an alternative to mandatory foster care placement.[63] The program consists of home-based therapeutic and case management services, including substance abuse assessment and counseling.[64] Available data indicates that mothers averaged a ten-

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54. *See* Camp & Finkelstein, *supra* note 50, at 411-22.

55. *See generally* Coletti et al., *supra* note 49; Shirley D. Coletti et al., *PAR Village for Chemically Dependent Women: Philosophy and Program Elements*, 12 J. SUBSTANCE ABUSE TREATMENT 289, 289-96 (1995); Hughes, *supra* note 51, at 66.

56. *PAR Village for Chemically Dependent Women*, *supra* note 55, at 290.

57. *Id.* at 292.

58. Coletti et al., *Specialized*, *supra* note 49.

59. *See* Zlotnick et al., *supra* note 49.

60. The program specifically targets mothers with children who are infants up to age three. *Id.* at 197.

61. *Id.* at 198-200.

62. *See* Lenore J. Olsen, *Services for Substance Abuse-Affected Families: The Project Connect Experience*, 12(3) CHILD & ADOLESCENT SOC. WORK J. 183 (1995).

63. *Id.* at 184.

64. *Id.* at 185.

month stay,[65] 62% of mothers made gains in their drug problem,[66] and 45% of mothers were reunited with their children, compared to 18% of mothers who did not enter treatment.[67]

The Women's Residential Treatment Center at the Center for Drug Free Living in Orlando, Florida, extends residential services to both substance abusing mothers and their children.[68] The facility offers on- and off-site GED classes, computer facilities, on-site medical facilities, and a day care center and nursery.[69] Outcomes indicate that while only 38% of participants successfully complete treatment, 88% of these participants reside at the treatment center with their children.[70] Additionally, mothers who live with their children at the center remain in the program for an average of 253 days, compared to ninety-two days for mothers who reside in the program without their children.[71] Data also indicates that mothers remain in treatment longer and are more likely to remain drug-free if their children reside with them early in treatment.[72] These mothers also exhibit higher self-esteem and lower depression compared to mothers living at the center alone.[73]

The Amity treatment program is located on a twenty-three acre ranch in Phoenix, Arizona.[74] The facility offers residential services for women and their children, and the program lasts fifteen to eighteen months.[75] Six-month post-treatment outcome data indicates that only 31% of those who completed treatment had used drugs, compared to 64% of those who did not successfully complete

65. *Id.*
66. *Id.* at 187.
67. *Id.* at 190.
68. *See* Wobie et al., *supra* note 49.
69. *Id.* at 591-92.
70. *Id.* at 594-95.
71. *Id.* at 593.
72. *Id.* at 596-97.
73. *Id.* at 598-99.
74. *See generally* Sally J. Stevens et al., *Women and Children: Therapeutic Community Substance Abuse Treatment, in* COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS 129 (George de Leon ed., 1997); Sally J. Stevens & Naya Arbiter, *A Therapeutic Community for Substance-Abusing Pregnant Women and Women with Children: Process and Outcome,* 27 J. PSYCHOACTIVE DRUGS 49 (1995); Sally J. Stevens et al., *Women Residents: Expanding Their Role to Increase Treatment Effectiveness in Substance Abuse Programs,* 24 INT'L J. ADDICTIONS 425 (1989).
75. Stevens & Arbiter, *supra* note 74, at 52.

treatment.[76] Additionally, 77% of those who completed were working six months after treatment, while only 48% of dropouts were employed.[77] Lastly, twelve-month follow-up data indicates that only 15% of those who completed treatment had been arrested, compared to 47% of the dropouts.[78]

Drug treatment programs designed for women and their children are receiving increased attention across the country. Many innovative programs have been piloted in Florida. It is important to note, however, that services for women and their children currently represent only a small fraction of available services.[79] In Hillsborough County, no residential programs for women and their children currently exist.

V. LOCAL ANALYSIS

A. Ongoing Working Group Discussions

Between January and July of 2001, a working group of professionals in Hillsborough County discussed issues related to linking women to and sustaining women in substance abuse treatment, particularly those women involved in dependency court. This diverse group provided a wealth of knowledge and important perspectives, including their thoughts about the treatment referral process for women in Hillsborough County dependency court. They also facilitated a service system mapping exercise and key informant interviews.

1. Key informant interviews

Key informant interviews were conducted with four important and informed groups: (1) DCF employees involved in case plan development; (2) substance abuse treatment professionals; (3) dependency court staff; and (4) substance abuse treatment

76. *Id.* at 54.
77. *Id.*
78. *Id.*
79. Child Welfare League of America, Alcohol and other Drugs Fact Sheet (2001), *available at* http://www.cwla.org/advocacy/aodfactsheet.htm.

participants, most of whom were involved with DCF and dependency court. Informed consent was obtained, and a standard series of questions were asked. Questions ranged from services this population needs to issues of motivation and retention in treatment. Interviews took sixty to ninety minutes to complete.

2. Results of key informant interviews[80]

a. What kinds of services do women facing abuse or neglect charges typically need?

Women involved in dependency court need a range of services, including some that previously may not have been considered within the bounds of traditional service delivery. Respondents described the need for transportation, child care, housing, clothing, medical evaluations, educational or vocational assistance, and mental health services, in addition to substance abuse treatment. Many women need assistance in dealing with their children's school system, in addressing their children's medical needs, and in acquiring fundamental parenting skills. Most of these women have mental health disorders in addition to their substance use and require long-term treatment with a counselor or case manager. Many have had traumatic experiences and need interventions that address sexual abuse and domestic violence.

b. Is treatment readily available? What, if any, barriers exist?

Outpatient treatment is available, but individual therapy, family-oriented therapy, and residential treatment are extremely limited or unavailable.

Financial limitations present a huge barrier to getting substance abuse treatment. When living at the poverty level, having to pay for such things as cab fare, bus fare, and babysitting poses obstacles to engaging in treatment. In many cases, clients must pay for an initial evaluation, which can also be a barrier to entering treatment.

80. Responses to key informant interviews have been collapsed across informant groups.

Furthermore, the cost of weekly urine tests can be prohibitively expensive.

Many other barriers to obtaining treatment exist, particularly because current treatment models still discharge participants if they do not comply with treatment demands. For example, when case plans have overlapping requirements, participation in treatment may make it impossible to accomplish other case plan requirements, such as acquiring a job. While access to day care may allow parents to continue treatment, the lack of afternoon and evening childcare often prevents parents from acquiring jobs. Mothers may also be dissuaded from initiating treatment until a treatment plan is legally formalized, which often takes a long time, as recommendations may be made weeks or months after the initial investigation. Additionally, women are often offered housing that is far from their treatment facility and in an unsafe area. Many women have little social support, so if their car breaks down or they need child care no assistance is available, and often caseworkers have limited familiarity with available treatment services and with a woman's needs.

c. How does substance abuse get identified? What barriers exist to identification?

There are no standardized questions about substance abuse. Furthermore, if substance abuse is not identified in the initial investigation, it is unlikely to become part of the case plan, and legal issues prohibit introducing drug abuse at a later date. For example, drug tests are not routinely done during the initial evaluation, and a judge will not admit the results of a drug test if there is not a clear indication of why the test was performed.

Individual investigators may have limited information and experience regarding drug abuse and addiction because they are forced into dual roles of advocating both for and against reunification. Thus, they may find that they are conflicted about helping the mothers. Additionally, some dependency court staff are uncertain as to whether so much emphasis should be placed on substance abuse treatment when other identified needs—such as parenting skills, mental health treatment, and financial assistance—exist.

Referral to substance abuse treatment is variable, and can hinge on the type of drug the mother uses and the circumstances surrounding her use. Treatment involvement is not thoroughly assessed through the court process. If clients have only attended and participated minimally, they will probably receive credit for meeting the requirements of their case plan, even though the treatment provider may feel strongly that the woman has not really received full treatment.

d. How does communication work between the court, the social service system, and treatment service providers? Are demands placed on systems that cannot be met?

Few, if any, links exist between the dependency court staff, the investigating caseworkers, and service providers. Providers have no direct line of communication with the judge to inform him or her how the individual is doing in treatment, and they are not routinely asked to go to court or provide updates on client progress. Furthermore, the case plan review does not focus heavily on treatment compliance.[81]

Accessing treatment can be complicated further if a woman has to wait for money to be appropriated so she can get a treatment evaluation. It may take days or weeks to get an appointment for an evaluation, so a woman can know if substance abuse treatment is recommended. Once the evaluation is complete, the document recommending treatment must work its way through the court system. The result is a four to six month delay before the woman is officially referred to substance abuse treatment. During this delay, the ASFA timeline continues, increasing the likelihood that the court will terminate the mother's parental rights.

The manner in which information is communicated also affects how cases are handled. Investigators may offer treatment compliance reports, but if they do not provide documentation, the judge may not necessarily weigh the information heavily when making his or her decisions. However, a judge may take a mother's report of treatment

81. A caseworker offers what is a common scenario: "The day before a court hearing, the client may call to get an appointment for an evaluation, she gets an appointment for two weeks later, judge continues it for six months, client skips the appointment." Hills et al., *supra* note 1.

compliance as fact and continue the case for several months, without asking for any further feedback from the treatment provider.

e. What is working well in the system? What are areas that could use improvement?

Communication among providers has improved, particularly because monthly meetings provide an opportunity to staff difficult cases and expand resource bases. The treatment community has also started to incorporate evidence-based models of family intervention. Initial steps have been taken to co-locate substance abuse providers and child protective investigators.

Improvement in the area of efficiency is needed, as each agency has it own caseworker, which means multiple and often redundant home visits, interviews, and case plans. Furthermore, ASFA accelerated the timeline for terminating parental rights,[82] which makes achieving symptom, housing, and economic stability a very intense process for women with multiple deficits. Reunification attempts are also stressed, because the average mother only gets to visit her children for one hour, once a month.

Relationships between parties can be difficult at times. Caseworker turnover complicates the picture, as mothers often have to establish a relationship with a new caseworker in the middle of the court process. Also, the paperwork burden on caseworkers is tremendous, which limits the amount of time that they can follow up with clients who are not attending treatment or who have other special needs.

Limited training is often cited as a problem. For example, the current guardian *ad litem* system is comprised of volunteers who represent children, but they might not be aware of social or cultural family norms. Caseworkers also have limited training, specifically regarding substance abuse indicators. While their training gives them an overview, caseworkers would benefit from more shadowing and role-playing experiences, which will make them more comfortable with the experience.

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82. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115, 2118-2120 (codified as amended in scattered sections of 42 U.S.C.).

Within the Hillsborough County practice community, residential services for women and their children are largely unavailable. Transportation to treatment is available in some programs. Current treatment programs are not designed for long-term contact, which makes it much more difficult for mothers to achieve symptomatic, behavioral, vocational, and economic goals. Women in Hillsborough County dependency court often need housing, but arrest records often prevent their approval, which, in turn, prevents reunification. Furthermore, women who have severe medical or mental health needs do not receive all of the services they need while in substance abuse treatment, because those services are not integrated. One treatment provider's comment illustrates the problems that exist within the current system: "[i]f you have a 28-year-old mom with four kids who is pregnant, she has an eighth grade education, never held a job, has no husband . . . your program has to get her out in six to nine months but this is not enough time to work with her to get her out of the system permanently."

f. What keeps a woman motivated to stay in treatment?

Despite their serious addictions, most women want to get their children back. While they can lose motivation to address their substance dependence after their parental rights are terminated, they often return to treatment after having another child and getting involved in a new dependency court proceeding. While access to her children during treatment can keep a mother motivated to remain in treatment, unlimited access—such as when children are placed with a relative—may slow the pace of her recovery.

g. What makes it hard for a woman to succeed in treatment and avoid relapse?

The jobs available to this population of women tend to be in the service industry, are low paying and do not foster independence. Furthermore, it is very difficult to reconcile the demands of treatment with the need to work. Many of the mothers involved in dependency court are also involved in criminal court proceedings. It is difficult for women to meet both dependency and criminal court requirements,

and sometimes they feel it might be easier to ignore the requirements and go to jail.

h. Women discuss their perspectives on the dependency court process

Women who are in substance abuse treatment as part of their dependency court requirements felt that the counselors with whom they interacted needed to know more about addictions and the recovery process. Women often felt that the parties involved in the process expected changes to "happen overnight" and that these expectations were unrealistic. They described the need for greater emphasis on family-based interventions and greater use of peers as role models.

Women stated they were devastated by the loss of their children and the loss of information about their children's behavioral patterns. They wished that their children could access more services while in foster care. Overall, they requested more frequent visitation, communication, and contact. Women also uniformly expressed a need for stable housing and safe working environments. One woman stated, "[w]e need to have a stable place; you can't be working in the labor pool and living on the street or on the verge of homelessness."

3. Review of foster care data files

The working group obtained hard copies of seventy-three data files that had been previously extracted from the case records of families involved in Hillsborough County dependency court. The working group reviewed these files to determine if they contained various substance abuse indicators. The files included information related to critical incident reports, case plans, and data on parental substance abuse evaluation, diagnosis, and treatment. Each file was examined for the following: substance abuse indicators or treatment history in the report made during the initial abuse or neglect investigation; referrals to substance abuse treatment; evidence that the parent was evaluated for a suspected substance abuse problem; evidence that the parent initiated substance abuse treatment; and evidence that the parent was diagnosed with a substance use disorder.

4. Results of the extracted file review

The data files were examined for critical incidents related to substance abuse.[83] Of the seventy-three files reviewed, thirty-three (45%) listed parental substance abuse as a critical incident. The custodial or care-giving parent was diagnosed with a substance use disorder in forty-four (60%) of the cases.

Despite the high rate of cases involving parental substance abuse, only nine (12%) recommended substance abuse treatment as part of the case plan. However, some parents did receive substance abuse treatment during the course of their dependency court involvement, despite the relative scarcity of case plan recommendations. Twelve cases (16%) had at least one parent enrolled in substance abuse treatment, and twenty-one cases (29%) had at least one parent who underwent a substance abuse evaluation.[84]

This limited file review suggests that services as basic as substance abuse evaluations are not routinely recommended as part of case plans, despite the fact that many of these files indicated a history of parental substance abuse that was likely tied to the child abuse and neglect.

VI. OBSERVATIONS AND RECOMMENDATIONS

Many cases of abuse and neglect may be identified before it is necessary to remove children from their homes. Social service agencies need to review their child abuse identification training. Agency staff also need to be knowledgeable about the community resources available to support families. Because there is a high rate of caseworker turnover, training poses a challenge. Agencies need to offer frequent networking or training activities that familiarize staff with available community resources.

People who receive community support are less likely to face abuse or neglect charges. Thus, communities and public health

83. Child welfare workers define critical incidents as those circumstances prompting a child's removal from the home.

84. The assumption was made that those involved in treatment underwent an evaluation prior to the start of their treatment.

departments need to invest funds in child abuse prevention through innovative models of support and care.

Identifying substance abuse as a contributing factor is crucial in initial abuse or neglect investigations. Investigators and caseworkers need clear instruction regarding the extent to which substance abuse should play a part in child abuse or neglect reports. If standardized questions are employed, decision rules should be developed to help guide the case plan development process. Children's services should seek input from defense attorneys and judges involved in the dependency court or family drug court process regarding these decisions.

Investigators and caseworkers need methods to assess a custodial parent's level of substance abuse and its threat to the child's safety. The Annie E. Casey Foundation has a training module available to assist caseworkers in recognizing and assessing substance abuse patterns.[85] The Casey materials discuss how to pursue interviews with parents who are suspected of being acutely intoxicated.[86] Child welfare workers are responsible for determining the degree to which parental drug use poses a risk to the child; thus, it is imperative that they are trained not only to identify substance use related problems, but also to determine the potential risks that such use poses. Drug problem identification and management training should be part of new employee orientation, in-service training, and refresher courses.

The criteria used to determine when to remove a child from the home and when to refer a parent to substance abuse treatment are unclear. Further efforts should be made to give investigators and caseworkers clearer guidelines. Standards, guidelines, and definitions regarding the level of substance or alcohol abuse that is considered harmful to children need to be developed and disseminated. Furthermore, referral processes for substance abuse treatment are not systematic. Even when disorders are identified, caseworkers do not always initiate referrals, and are often unfamiliar with the community treatment resources available to their clients.

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85. Annie E. Casey Foundation, Family to Family Tools, *at* http://www.aecf.org/initiatives/familytofamily/tools.htm (last visited Oct. 25, 2003) (on file with the Washington University Journal of Law & Policy).

86. *Id.*

A great deal of literature exists that supports the use of escorts and transportation to facilitate a successful referral process.[87] For example, innovative models of peer mentoring are used in some areas.[88] The court system needs to support the early identification of mothers with substance use disorders, so they can be referred to treatment quickly. Additional resources, strategies, and collaborative efforts are needed to accomplish higher rates of successful referrals; and service providers and referring agencies need to systematize the evaluation process so that appointments can be made, evaluations conducted, and findings forwarded to the mother and the court.

Many factors complicate the ability to move from evaluation to treatment. Decreasing the time between a client's referral to treatment and the initial appointment has been advocated for many years,[89] and has been found to be effective with alcoholics,[90] drug-free outpatients,[91] and methadone clients.[92] Court system issues that delay case plan adoption and treatment recommendations work against a mother trying to move into recovery and reunify with her children. Methods for rapid referral and engagement need to be evaluated and accepted by all parties.

Despite a court's recommendation for substance abuse treatment, most women do not become successfully engaged in treatment. Research indicates that engagement improves when there is greater outreach on the initial contact, including using incentives for and escorts to treatment.[93] Though some strategies have been employed to

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87. *See, e.g.*, Mary Ann Chutuape et al., *Methods for Enhancing Substance Dependent Patients from Inpatient to Outpatient Treatment*, 61 DRUG & ALCOHOL DEPENDENCE 137 (2001); Robert E. Both et al., *Substance Abuse Treatment Entry, Retention, and Effectiveness: Out-of-treatment Opiate Injection Drug Users*, 42 DRUG & ALCOHOL DEPENDENCE 11 (1996).

88. Peer mentoring is a component of the SISTERS Program in South Bronx, New York. ADDICTION AND PREGNANCY: EMPOWERING RECOVERY THROUGH PEER COUNSELING (Barry R. Sherman et al. eds., 1998).

89. Frederick Baekeland & Lawrence Lundwall, *Dropping Out of Treatment: A Critical Review*, 82 PSYCHOL. BULL. 738 (1975).

90. William R. Miller, *Motivation for Treatment: A Review with Special Emphasis on Alcoholism*, 98 PSYCHOL. BULL. 84 (1985).

91. Michael J. Stark et al., *Hello, May We Help You? A Study of Attrition Prevention at the Time of the First Phone Contact with Substance-Abusing Clients*, 16 AM. J. DRUG AND ALCOHOL ABUSE 67 (1990).

92. George Woody et al., *Rapid Intake: A Method for Increasing Retention Rate of Heroin Addicts Seeking Methadone Treatment*, 16 COMPREHENSIVE PSYCHIATRY 165 (1975).

93. *See* sources cited *supra* note 87.

facilitate referrals to treatment, increased contact between caseworkers and treatment staff will further facilitate successful engagement. The application of specific motivational interventions, such as Motivational Enhancement Therapy would also influence engagement and retention rates.

The number of available treatment services must increase to meet the rising demand for substance abuse treatment. In many communities, substance abuse treatment is very limited. Few programs link specialized services for women with on-the-job training and housing assistance. Women with mental health disorders and histories of substantial physical and sexual trauma may need several years of counseling, vocational training, and housing assistance before they can support their families and exist independently. However, current treatment programming takes a short-term perspective, even with women who have such complex rehabilitative needs.

The growth of family dependency drug court or family drug court strategies should be encouraged. As substance abuse may be a contributing factor in 60% to 90% of all dependency court cases, it is recommended that whether or not a judge is operating in the context of a family drug court, the court should require that parents participate in substance abuse treatment.[94] Courts should also ensure that the programs to which they are referring women use techniques to engage women in treatment and comprehensively address the complex issues that women face. Judges must communicate with treatment providers and work to reduce the adversarial nature of treatment recommendations. Finally, courts should encourage and monitor women's ongoing participation in treatment, thus recognizing the importance of this intervention in improving the parent-child relationship.

Caseworkers, court workers, and judges need information about the role of relapse in substance abuse treatment, particularly that successful outcomes can be achieved after multiple failed attempts at

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94. Nancy Young, Oral and Written Testimony to the House of Representatives Committee on Ways and Means Subcommittee on Human Resources on the Impact of parential Substance Abuse on Placement of Children in Foster Care (Mar. 25, 2000), *available at* http://www.cffutures.com/Presentations/Testimony300.pdf.

sobriety. All people involved in dependency court actions should be trained regarding what constitutes effective substance abuse treatment and the typical patterns of relapse and recovery.

Caseworkers and court personnel remain uncertain as to whether substance abuse treatment is effective and whether it is likely to reduce the odds of a family returning to dependency court. Additional research should be conducted to follow families with both substance abuse problems and child welfare involvement to demonstrate whether engagement in substance abuse treatment improves parental rights and family reconciliation.

CONCLUSION

Obviously, the psychological complexities of substance use disorders interfere with a parent's ability to judge the safety of children in their care. At a time when they are seriously afflicted with a substance use disorder, the child welfare and treatment systems challenge mothers. These systems, however often are limited in their knowledge and ability to recommend and deliver the comprehensive array of services that these mothers need. A significant effort should be made to improve the relationship between the court, child welfare workers, and treatment providers. Funding agencies must provide leadership and financial support for innovative models of evidence-based practice that can increase the likelihood of long-term positive outcomes for these families.

Child Abuse & Neglect

Learning from Research and Practice

Profiles of Child Abusers

Resiliency & Developmental Assets

Challenges

Solutions

Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Child Abuse and Neglect

- Abuse
  - Emotional
  - Physical
  - Sexual
- Neglect
  - Emotional Supports
  - Basic Care
  - Protection from Harm

Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Profiles of Child Abusers

High Risk Parent(s) and Care Giver(s)

- Childhood and Life Experiences
- Family and Community
- Poverty
- Domestic Violence
- Substance Abuse and Mental Health

Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Resiliency and Developmental Assets

- Resiliency – Life Stage and or Locale
  - Protective Factors
  - Risk Factors
- Developmental Assets
  - External Assets
    - Support, Empowerment, Boundaries and expectations, Constructive use of time
  - Internal Assets
    - Commitment to learning, Positive values, Social competencies, Positive identity

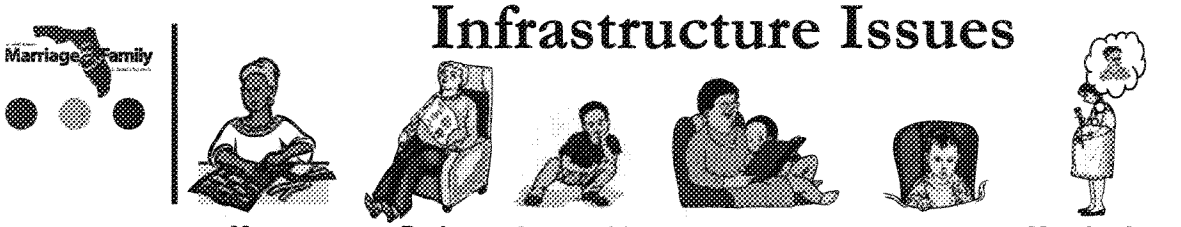
Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Challenges

- Family Formation
  - Structures
  - Attitudes
  - Correlates of Healthy Intimate Relationships
- Strengths and Needs Assessments
  - National Comparisons
  - State Trends

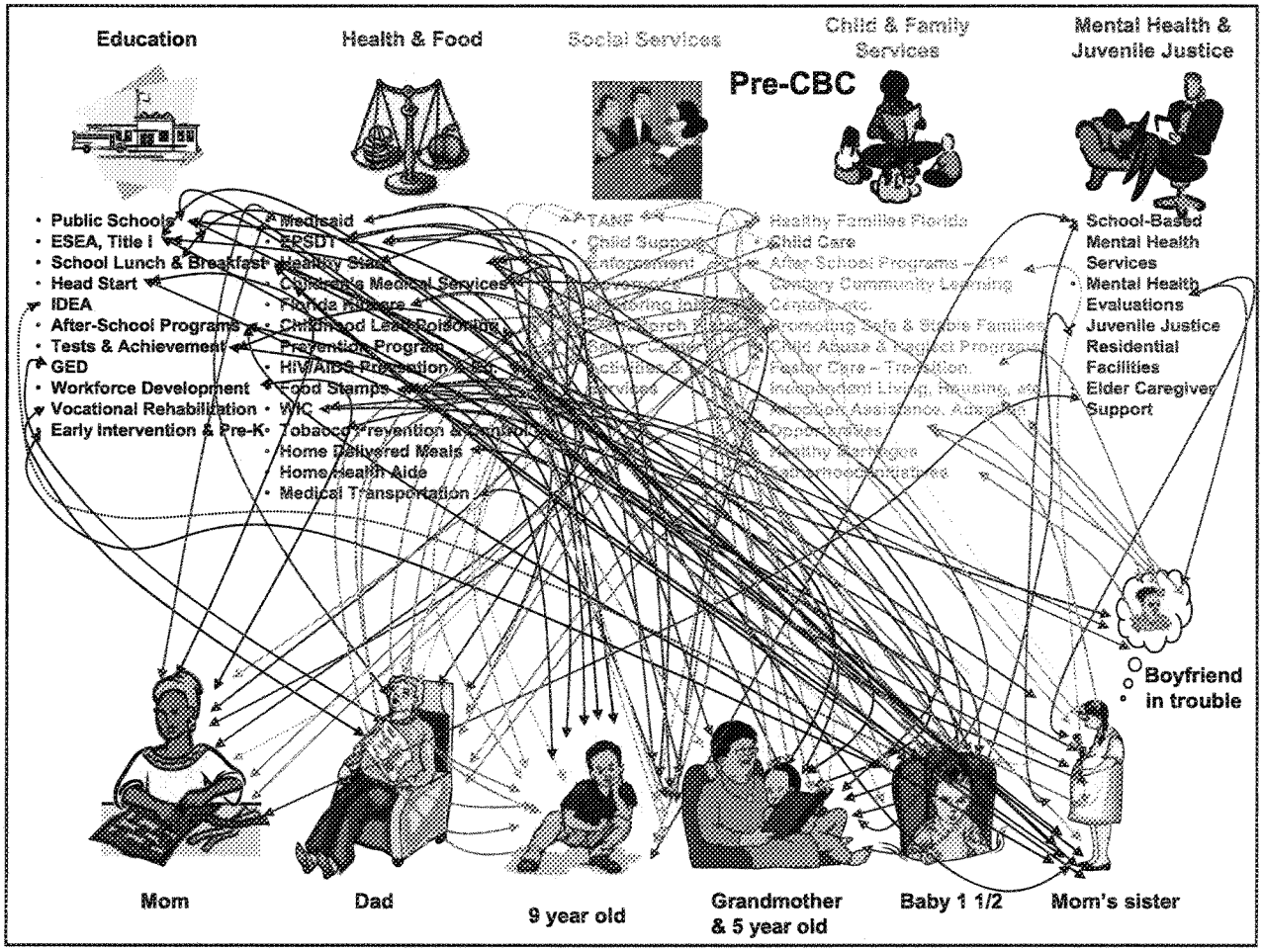
Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Infrastructure Issues



- Good Health – Get health insurance; find out why the youngest isn't talking anymore; keep Grandma healthy; & have a healthy baby.
- Safety & Survival – Keep the children away from drugs & the sister's boyfriend; & keep the family together.
- Economic Well-Being – Have the husband get back to work; have the wife keep her job; & get training for better jobs.
- Social & Emotional Well-Being – Help the sister thru her pregnancy & stay in school in the meantime.
- Education & Workforce Readiness – Help the 9-year-old do better in school, & figure out the problem with the 1 ½ year old.

Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida


Education
Health & Food
Social Services
Child & Family Services
Mental Health & Juvenile Justice
Pre-CBC
• Public Schools
• ESEA, Title I
• School Lunch & Breakfast
• Head Start
• IDEA
• After-School Programs
• Tests & Achievement
• GED
• Workforce Development
• Vocational Rehabilitation
• Early Intervention & Pre-K
• Medicaid
• EPSDT
• Healthy Start
• Children's Medical Services
• Florida Kidcare
• Childhood Lead Poisoning Prevention Program
• HIV/AIDS Prevention & Ryan White
• Food Stamps
• WIC
• Tobacco Prevention & Control
• Home Delivered Meals
• Home Health Aide
• Medical Transportation
• TANF
• Child Support Enforcement
• Healthy Families Florida
• Child Care
• After School Programs – 21st Century Community Learning Centers, etc.
• Promoting Safe & Stable Families
• Child Abuse & Neglect Programs
• Foster Care – Transition
• Independent Living, Housing, etc.
• Adoption Assistance, Adoption Opportunities
• Healthy Marriages
• School-Based Mental Health Services
• Mental Health Evaluations
• Juvenile Justice Residential Facilities
• Elder Caregiver Support
Boyfriend in trouble
Mom
Dad
9 year old
Grandmother & 5 year old
Baby 1 1/2
Mom's sister

Solutions

- Primary Prevention
- Secondary Prevention
- Tertiary Prevention

Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Old Data – Costs of NOT Preventing Child Abuse and Neglect in 2001

$94 Billion per year

$258 Million per day

$1,462 per family

Direct Costs

- Health Care System
- Mental Health Care System
- Child Welfare System
- Law Enforcement
- Judicial System

Indirect Costs

- Special Education
- Mental Health & Health Care
- Juvenile Delinquency
- Lost Productivity to Society
- Adult Criminality

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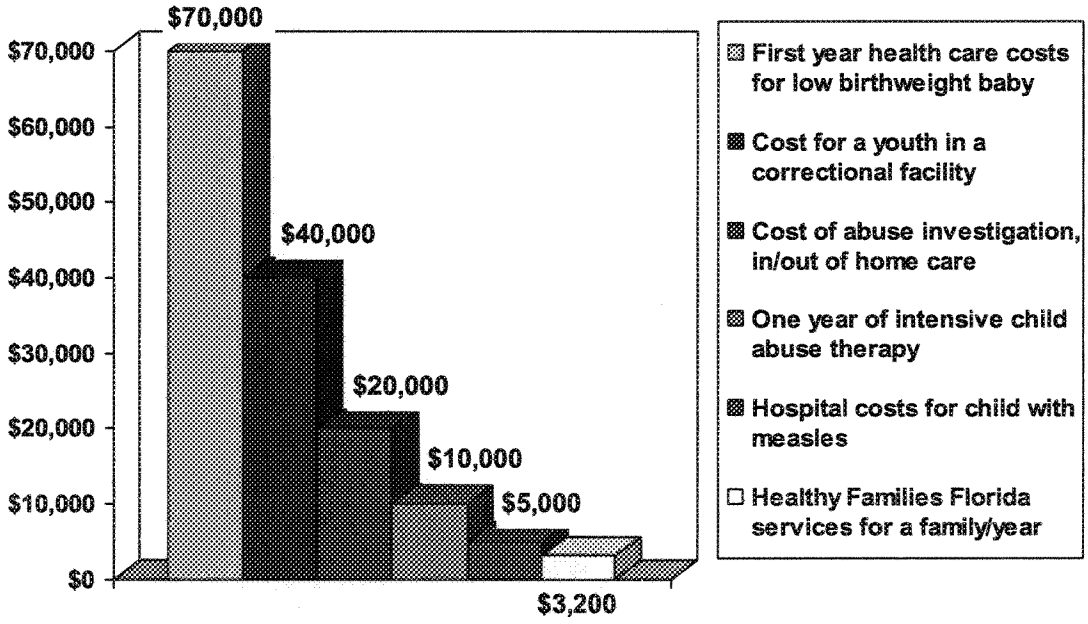
More Old Data –

Prevention is a Sound Investment



(From: www.healthyfamiliesfla.org/facts.html Sources: Florida Department of Children and Families, Healthy Families America and the Center for Florida's Children)

Solutions

Secondary Prevention

Healthy Families Florida – a proven, national model

Imagine if every mother who met the risk criteria could have access to such quality and effective services!

Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Solutions - Primary Prevention

Integrated, coordinated, family-centered systems of natural (healthy community) and specialized supports

<u>Build Protective Factors</u>

- Good Health
- Safety & Survival
- Economic Well-Being
- Social & Emotional Well-Being
- Education & Workforce Readiness

<u>Reduce Risk Factors</u>

- Poverty
- Domestic Violence
- Substance Abuse and Mental Health

Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

Child Abuse & Neglect

Learning from Research and Practice

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Future of Florida's Families Committee, Prevention of Child Abuse and Neglect Public Hearing, Miami, Florida

A Closer Look at Those who Abuse and Neglect Children

Child abuse and neglect encompass a spectrum of actions, from acts of commission to acts of omission. Abuse occurs in a wide array of forms such as physical, emotional, and sexual. Rarely are children abused by strangers. Abuse can start even when a child is conceived, and this prenatal abuse can have long term adverse effects on the child. For example, maternal drug abuse and failure to seek appropriate prenatal health care during pregnancy could result in pre-term labor, low birthweight babies and potential for life long developmental delays. Abuse can occur in the crib with long lasting adverse effects for the child from brain damage to psychiatric disturbances to violence towards self and others.

Neglect accounts for more deaths than physical abuse. Neglect can include failure to provide adequate medical care, nutrition, clothing, heat, basic shelter, and protection from environmental hazards. These and other forms of neglect could lead to a baby's failure to thrive or be the direct cause of injury or death to a child.

Neglect and Physical and Emotional Abuse

Over 90 percent of abusive and neglectful parents do not have a psychotic or criminal personality. Risk factors and co-occurring challenges found in perpetrators of neglect and abuse include:

Childhood and Life Experiences
- Less than a high-school education
- Abused as a child

Family and Community
- Single parenting – sole responsible caregiver
- Unplanned pregnancy; a sense of hopelessness upon knowledge of pregnancy
- Lack of parenting skills
- Little awareness of discipline options; confuses punishment with discipline (teaching)
- Limited or no natural supports; little or no family or friends to assist them
- Isolated; lonely
- Little or no knowledge of child care and child development
- Have unrealistic expectations for child behavior
- Increased violence in the communities where they live
- Limited education
- Mentally handicapped parents

Poverty
- Low income or multiple employment in order to have a livable wage
- Increased number of crises in their lives
- Inadequate housing
- Limited access to economic or social resources for support during times of stress

Family Violence
- Abused or neglected as a child
- A prior report of maltreatment
- Currently a victim of domestic violence or spousal abuse

Substance Abuse and Mental Health

Smoking during pregnancy
Use of alcohol or other drugs
Physical response to anger
Mental health problems
Chronic illness

Children at high risk of being abused:

Children with parents experiencing the risk factors above.
Mentally retarded children
Premature infants
Infants with chronic medical problems
Colicky babies
Children with behavioral problems

Children who have been physically abused, even as infants, have a greater likelihood of presenting with a multitude of psychiatric disturbances:

- Anxiety
- Aggressive behavior
- Paranoid ideation
- Posttraumatic stress disorder
- Depressive disorders
- Suicidal risks are increased
- Poor self esteem
- Depression
- Dissociative disorders
- Substance abuse (alcohol, drugs)
- Violent behavior/outbursts

Sexual Abuse

Most of the increased numbers of child abuse is in the increase in the reporting of sexual abuse and the publicity surrounding sexual abuse. Sexual abuse is defined as involving any minor child (age dependent upon state/country) that is intended for the sexual gratification of an adult. In studies of juvenile offenders, younger perpetrators tend to have younger victims, but are more likely to have intercourse with older victims. Sex acts by young children, between young children is a learned behavior and are associated with sexual abuse or exposure to adult sex or pornography. Sexual abuse most commonly occurs by an individual known by the victim, parent or other family member (intrafamilial). Rarely is the abuser a stranger.

Profile of Sexual Offenders

1. 97% are male who are on the average 10 years older than their victims.
2. Females are more often perpetrators in child-care settings, including baby sitting.
3. Abuse by females may be higher than reported due to younger children confusing sexual abuse with normal hygiene care and adolescent males may not be trained to recognize sexual activity with an older female as a form of abuse.
4. Sexual abuse by stepfathers is 5 times higher than among natural fathers, the most common age for onset of abuse is age 10.
5. Abuse of daughters by fathers and stepfathers is the most common form of reported incest. Commonly the mother is unavailable to the father and is usually chronically ill or depressed. The mother is commonly the victim of child abuse when young.

6. Brother-sister incest is the most common form of incest (but not the most commonly reported).

Incest

Incestuous fathers, a profile

Rigid
Patriarchal
Emotionally immature
Alcohol or drug abuse
Usually do not engage in extramarital affairs

Mothers in the home where father-daughter or son incest

Chronically depressed
Chronically ill
Work takes them away on business trips overnight
Show little or no interest in their husbands sexually

Pedophilia

Pedophiles become sexually attracted to children begins in their adolescence. Pedophiles seek opportunities that place them in and around children. The common victim profile of a pedophile is:

1. Mental and physical handicaps
2. Unloved, unwanted children
3. Previously abused children
4. Children of single parent families
5. Children of drug abusing parents
6. Children with low self esteem
7. Children who are poor achievers

References

Emergency Medicine 4th Ed. Tintinalli, MD Ruiz, MD McGraw Hill, 1999.

Ghosts from the Nursery, Tracing the Roots of Violence. Karr-Morse & Wiley, The Atlantic Monthly Press, 1997.

Healthy Families Florida Screening Instrument Healthy Families Florida, 2005.

Kaplan *and Sadock's Synopsis of Psychiatry Behavioral Sciences in Clinical Psychiatry*, 7th Ed. Arnold Kaplan, MD Benjamin Sadock, MD Jack Grebb, MD Williams&Wilkins, 1999.

Nelson Textbook of Pediatrics Behram, Kliegman, Arvin. 15th Ed. Saunders 2001

Primary Care Geriatrics 3rd Ed. Ham, MD Sloane, MD Mosby, 1999.

The Childhelp USA® National Child Abuse Hotline, 1-800-4-A-CHILD® (1-800-422-4453) available 24 hours/day.

Mission: *to strengthen marriages, support parents and families, and promote child well-being by raising public awareness, developing sound public policy and advocating for promising practices throughout Florida.*

RESILIENCY

A WHITE PAPER PREPARED FOR THE COMMISSION ON MARRIAGE AND FAMILY SUPPORT INTIATIVES

Children come into the world trusting until they are taught to distrust by adults who cannot be trusted.

Children come into the world without hate and racial prejudice until they are taught by adults who hate and are prejudiced.

Children come into the world resilient and full of joy and laughter until they are discouraged, demeaned, and stigmatized by the low expectations, unjust labels, and mistreatment of adults.

Children come into the world with promise and potential until they are pampered into laziness, purposelessness, and sense of entitlement by too much wealth and too little challenge or trapped into failure by too much hunger, loneliness, poverty, and illiteracy.

Marian Wright Edelman in *Lanterns A Memoir of Mentors,* 1999

Created in 2003 (s. 383.0115, Florida Statutes), the ***mission*** of the Commission on Marriage and Family Support Initiatives is to strengthen marriages, support parents and families, and promote child well-being by raising public awareness, developing sound public policy and advocating for promising practices throughout Florida. In keeping with this mission, this white paper has been developed in order to describe the facets and importance of resiliency as a goal for Florida.

The desired outcome for all children is that they are happy, healthy and experiencing proper growth and development so that they become productive adults; ready, willing, and able to contribute to self, to family, and to their community. There are numerous factors that affect whether marriage, family and child development proceeds with ease or a struggle. Child well-being is not an outcome that will be achieved by using a single strategy. Prevention of harm is the most cost-effective strategy. However, not all risk factors are preventable for every child. Two additional classes of strategies must also receive support. The first of these is programs that create resiliency in children, youth and adults so that, even if exposed to risk, they will have the tools needed to overcome the negative impact of risk factors. The second and most expensive strategy lies in programs that provide appropriate care for children, youth and adults for whom all preventive attempts to create a safe environment have failed. (CEED, 2004)

The focus of this paper is the importance of resiliency in strengthening the ability of Floridians, young and old, to seek and to live healthy and productive lives. What is **resiliency**? Webster's Dictionary defines resilience as the ability to recover from or adjust easily to misfortune or change. The Children's Board of Hillsborough County defines it as "the potential for youth to develop into healthy, productive, competent adults despite experiences of severe stress and adversity…a quality that characterizes children who, though

exposed to significant stress and adversity, do not succumb to the failures predicted for them...the innate, self-righting mechanism within every person that is engaged in active, on-going adaptation to his or her environment" (1997). If the cycles of violence in our homes and communities are to be broken, Florida must address resiliency, and the behaviors that can shore up resiliency, starting at a young age. Self-destructive behaviors, such as drug use and unprotected sex, have been linked to violence among college-aged individuals in relationships and to hitting and verbal abuse among adolescents just beginning to date. Adolescents who are engaging in relationship violence are more likely to continue this into adulthood. When they get into a marriage or cohabitation relationship, they are more likely to engage in domestic violence. (Durant, 1999; Roberts, 2003)

Risk and Protective Factors

Resiliency can be built in children by providing them with protective factors at the child, family and community levels. Researchers interested in the course of development have identified protective and risk factors associated with the well-being of families and children as a means of assessing, designing, and projecting support and service needs. **Protective factors** have been associated with positive school and life outcomes. Causal links between **risk factors** and poor school and life outcomes have been established.

Resiliency is decreased by the extent to which children, families and communities are exposed to risk factors. Some studies suggest that risk is cumulative, that is, the higher the number of risk factors over time, the greater the likelihood of subsequent emotional and behavioral problems. Others suggest that risk is additive, not cumulative. That is, children with a whole set of risks at one time are at a greater disadvantage than children that accumulate a few risk factors over a period of time. Findings do substantiate that children can move in and out of various levels of risk at different points in their life. (Peth-Pierce, 2000) Table 1 provides an overview of documented protective and risk factors linked to family and child well-being from the prenatal period through early childhood.

Table 1 Protective and Risk Factors

Prenatal	Protective Factors	Risk Factors
	✓ Good health ✓ Practice of risk reducing behaviors ✓ Adequate nutrition ✓ Neurodevelopmental intactness ✓ Normal fetal development	– Congenital anomalies – Respiratory disease – Poor nutrition – Prematurity – Perinatal conditions – Intrauterine drug use – Sexually transmitted disease – Low and very low birth weight – Poor maternal health – Maternal stress – Multiple births

TABLE 1. PROTECTIVE AND RISK FACTORS (CONTINUED)

Child	Protective Factors	Risk Factors
	✓ Good health ✓ Outgoing or easy temperament ✓ Positive or secure attachment to mother or other caregiver ✓ Developmentally competent and independent ✓ Higher cognitive functioning/normal intelligence ✓ Self-confident/high self-esteem ✓ Gets along with children and adults/has a large number of friends ✓ Warm and open relationships with early childhood teachers	– Poor child health, medical disorder – Difficult temperament, behavior, or mood – Insecure parent-child attachment – Developmental delays or difficulties – Cognitive impairment/ low intellect – Low self-esteem – Difficulty getting along with others
Family	**Protective Factors**	**Risk Factors**
	✓ Economic security ✓ Employment consistency ✓ Residence with both parents ✓ Routines and consistency in family life ✓ Family cohesiveness – stable, organized, predictable ✓ Emotional support from alternative caregiver ✓ Parent available in times of stress ✓ Psychological well-being of parents ✓ Satisfaction in parenting role ✓ Parent has high self-esteem ✓ Parent provides positive role model ✓ Parent provides supervision of child ✓ Higher level of maternal education ✓ Emotional closeness with and support from extended family and friends ✓ Good social skills ✓ Knowledge of methods for optimal birth spacing ✓ Good health ✓ Health awareness ✓ Positive social networks ✓ Strong paternal role in child's early life	– Prolonged economic distress/low socioeconomic status – Employment stress or unemployment – Single parent/teen parent – Blended families – Rapid and stressful life changes – Threats of or actual separation/divorce – Marital/relationship discord – Lack of support from others (e.g., extended family, friends, faith community, support groups) – Lack of a positive adult role model – Parent(s) with mental disorder – Parent(s) with unrealistic expectations poor self-regulation – Parent(s) with poor reasoning or problem-solving – Parent(s) with antisocial behavior – Poor adult supervision – Low level of maternal education – Isolation – Use of harsh, inconsistent discipline – Large number of children – Chronic parental illness – Parental disability – Parent(s) with substance abuse – Homelessness/inadequate housing – Criminal behavior/incarceration
Community	**Protective Factors**	**Risk Factors**
	✓ Safe neighborhoods ✓ Stable and cohesive neighborhood w/strong informal support networks ✓ Economic opportunities and supports ✓ Accessible services ✓ Accessible and affordable health care ✓ Health education and outreach ✓ Community resources for recreation and enrichment ✓ Quality, affordable child care ✓ Good transportation services ✓ Positive social networks and active neighborhood groups/organizations ✓ Effective prevention and early intervention services	– Immigrant or minority status/cultural isolation – Unsafe neighborhoods: crime, environmental hazards, transience – Social intolerance or discrimination – Neighborhood poverty – Lack of adequate housing – Lack of accessible and affordable health care – Lack of health education – Lack of recreational facilities and libraries – Lack of accessible and affordable child care – Lack of transportation – Lack of effective public education and information on services – Lack of services for young families

Sources: Peth-Pierce, 2000; Rugges, Coulter, Panacek, & Stone, 1995; & Thomlison & Lundgren, 2001

The importance of protective factors can not be overestimated. Ample evidence documents that children who begin kindergarten socially and emotionally ready – able to make friends, get along with others, and communicate well with teachers – are successful. Their success extends beyond good academic performance, decreased likelihood of grade retention, and lower rates of adolescent pregnancy and delinquency to better odds for obtaining higher education and vocational, relationship, and financial success.

In general, risk factors do not operate in isolation. Mothers who use drugs are also likely to smoke, drink alcohol, neglect their health, and have poor nutrition. For families and children with numerous risk factors, productivity and success often times is elusive. Early labeling can result in lower academic track placements, lower expectations from teachers and parents, and decreased likelihood of positive social interactions. (Peth-Pierce, 2000) Protective factors in the community are essential for these families but are too often unavailable or difficult to access. For example, access to prekindergarten and early intervention programs that might ameliorate these challenges is highly uneven. (National Research Council & Institute of Medicine, 2000)

Developmental Assets

Since 1989, the Search Institute has surveyed over two million youth across the United States and Canada. As a result of their work, the institute has identified developmental assets which are concrete, common sense, positive experiences and qualities essential to raising successful young people. Studies have shown strong and consistent relationships between the number of assets present in young people's lives and the degree to which they develop in positive and healthful ways. Similar to protective and risk factors, the greater the numbers of developmental assets experienced by young people, the more positive and successful their development; and the fewer the number of assets present, the greater the possibility youth will engage in risky behaviors such as drug abuse, unsafe sex and violence. The developmental asset framework is categorized into 20 external assets and 20 internal assets (The Search Institute, 2005)

External assets are the positive experiences young people receive from the world around them and are about supporting and empowering young people, setting boundaries and expectations, and facilitating positive and constructive use of young people's time. External assets identify important roles that families, schools, congregations, neighborhoods, and youth organizations can play in promoting healthy development.

A community's responsibility for its young people does not end with the provision of external assets. Caring adults must make a similar commitment to nurturing the internal qualities that guide positive choices and foster a sense of confidence, passion, and purpose. **Internal assets** identify those characteristics and behaviors that reflect positive internal growth and development of young people. These assets help young people make thoughtful and positive choices and, in turn, be better prepared for situations in life that challenge their inner strength and confidence.

Communities That Care is a program model developed primarily in the juvenile delinquency prevention field that attempts to mitigate risk factors and promote protective

factors to keep youth from engaging in risky behaviors and committing delinquent acts. In their October 1999 study for the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention, Dr. Richard Catalano, Dr. Rolf Loeber, and Kay McKinney found that timely, comprehensive school- and community-based interventions hold the greatest potential for preventing juvenile delinquency. The study's Work Group also found that programs involving a juvenile's family, school, and community are most effective in minimizing factors that contribute to serious violent juvenile offending and maximizing those that prevent delinquency. The Study Group's review of school and community-based interventions found the results of many interventions were encouraging. Programs adopted from the public health model- one that has traditionally addressed risk factors while also enhancing protective factors – can make a difference. The following interventions have shown positive effects in reducing risk and enhancing protection against adolescent antisocial behavior:

- Behavioral consultation for schools
- School wide mentoring
- Behavioral modification and reinforcement of pro-social behavior, good attendance, and strong academic performance
- School organization interventions
- Situational crime prevention
- Comprehensive community intervention that incorporates community mobilization, parent involvement, and education, and classroom-based social and behavioral skills curriculums
- Policing strategies including community policing and intensive police patrolling, especially in "hot spots"
- Policy and law changes that affect the availability and use of guns, tobacco, and alcoholic beverages
- Mandatory sentencing laws for crimes involving firearms
- Media interventions to change public attitudes and enhance the effects of other community- and school-based prevention strategies

Table 2 provides an overview of external and internal developmental assets associated with positive growth and development of children and youth.

TABLE 2 DEVELOPMENTAL ASSETS FRAMEWORK

External Assets	Internal Assets
✓ ***Support*** - Children and youth need to experience support, care, and love from their families, neighbors, and many others. They need organizations and institutions that provide positive, supportive environments. Areas of support include: 1. Family support 2. Positive family communication 3. Other adult relationships 4. Caring neighbors and neighborhoods 5. Caring alternative care and school climates 6. Parent involvement ✓ ***Empowerment*** - Children and youth need to be valued by their community and have opportunities to contribute to others. For this to occur, they must be safe and feel secure. Areas of empowerment include: 7. Community values children and youth 8. Children and youth receive and are seen as resources 9. Service to others 10. Safety ✓ ***Boundaries and expectations*** - Children and youth need to know what is expected of them and whether activities and behaviors are "in bounds" and "out of bounds." Areas of boundaries and expectations include: 11. Family boundaries 12. Alternative care, school and out-of-home boundaries 13. Neighborhood boundaries 14. Adult role models 15. Positive peer relationships 16. Positive expectations ✓ ***Constructive use of time*** - Children and youth need constructive, enriching opportunities for growth through creative activities, youth programs. Areas include: 17. Play and creative activities 18. Out of home and community programs 19. Religious experiences 20. Time at home	✓ ***Commitment to learning*** - Children and youth need to develop a lifelong commitment to education and learning. Areas of commitment to learning include: 21. Achievement expectation and motivation to mastery 22. Children are engaged in learning 23. Stimulating activity 24. Enjoyment of learning and bonding with school 25. Reading for pleasure ✓ ***Positive values*** - Children and youth need to develop strong values that guide their choices. Areas of positive values include: 26. Caring 27. Equality and social justice 28. Integrity 29. Honesty 30. Responsibility 31. Healthy lifestyle and sexual attitudes ✓ ***Social competencies*** - Children and youth need skills and competencies that equip them to make positive choices, to build relationships, and to succeed in life. Areas of social competencies include: 32. Planning and decision making observation and practice 33. Interpersonal skills and observation 34. Cultural competence and observation 35. Resistance skills and observation 36. Peaceful conflict resolution skills and observation ✓ ***Positive identity*** - Children and youth need a strong sense of their own power, purpose, worth, and promise. Areas of positive identity include: 37. Personal power 38. Self-esteem 39. Sense of purpose 40. Positive view of personal future

Source: The Search Institute 2004

According to the research conducted by the Search Institute (2004), assets have tremendous power to protect youth from many different harmful or unhealthy choices. To illustrate this power, these charts show that youth with the most assets are least likely to engage in four different patterns of high-risk behavior, based on surveys of over 217,000 6th- to 12th-grade youth in 318 communities and 33 states during the 1999-2000 school year.

High Risk Behaviors	0-10 Assets	11-20 Assets	21-30 Assets	31-40 Assets
Problem Alcohol Use	49%	27%	11%	3%
Violence	61%	38%	19%	7%
Illicit Drug Use	39%	18%	6%	1%
Sexual Activity	32%	21%	11%	3%

The same kind of impact is evident with many other problem behaviors, including tobacco use, depression and attempted suicide, antisocial behavior, school problems, driving and alcohol, and gambling.

In addition to protecting youth from negative behaviors, having more assets increases the chances that young people will have positive attitudes and behaviors, as these charts show.

Positive Attitudes and Behaviors	0-10 Assets	11-20 Assets	21-30 Assets	31-40 Assets
Exhibits Leadership	50%	65%	77%	85%
Maintains Good Health	26%	47%	69%	89%
Values Diversity	36%	57%	74%	88%
Succeeds in School	8%	17%	30%	47%

Overall, the goal is to help youth replace negative and risky behaviors with positive ones and to build the capacity to withstand the stressors that they most likely will encounter in life by increasing the number of assets our children will possess.

IMPLICATIONS OF THIS WORK FOR THE COMMISSION ON MARRIAGE AND FAMILY SUPPORT

Through the work of its clearinghouse the commission should provide research, policy briefs and information on program practices that heighten awareness for developing protective factors for children and families. Similarly, the clearinghouse should provide research, policy briefs and information on program practices that heighten awareness for reducing risk factors for Florida's children and families.

Research findings will focus on stressors facing families related to poverty, violence, and substance abuse and the impacts of these and other phenomena on family and child well-being. Providing proven solutions to ameliorating stressors would help facilitate communities in building the capacity to create strong neighborhoods and families and ensure a high quality of life.

REFERENCES

CEED (2004) *Florida's Children: Needs Assessment 2003/2004*, Tallahassee, FL. Community Enhancement and Educational Development Program of the Lawton and Rhea Chiles Center for Healthy Mothers and Babies. Online at *http://www.teamfla.org/downloads/Spring2004NeedsAssessment.pdf*

Catalano, R., Loeber, R. and McKinney, K. (1999) *School and Community Interventions to Prevent Serious and Violent Offending* for the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Washington, D.C. Online at http:/ /www.ncjrs.org/pdffiles1/ojjdp/177624.pdf

Children's Board of Hillsborough County. (1997). *A Conceptual Framework for Service Planning for Children and Families*, Tampa FL.

Edelman, M.W. (1999). Lanterns: A memoir of mentors. New York: Beacon Press.

Ghazvini, A. S. & Foster, B. (2003). *The Florida vision: A state that promotes the well-being of all its children.* Tallahassee, FL: The Policy Group for Florida's Families and Children.

National Research Council and Institute of Medicine (2000). *From neurons to neighborhoods: The science of early childhood development.* Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, (Eds). Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press.

Peth-Pierce, R. (2000). *A good beginning: Sending America's children to school with the social and emotional competence they need to succeed* [Monograph]. Bethesda, MD: The National Institute of Mental Health, The Child Mental Health Foundations and Agencies Network (FAN).

Ruggs, D., Coulter, M., Panacek, L., & Stone, W. (1995). *A conceptual framework for service planning for children and families.* Tampa, FL: Children's Board of Hillsborough County.

Search Institute (2005) Online at *http://www.search-institute.org/assets/*.

Search Institute (2004) *40 Developmental Assets*™, Minneapolis, MN. Online at *http://www.search-institute.org/assets/*.

Thomlison, B. & Lundgren, M. W., (2001). *Trends: Readiness for all children 2001.* Miami: School of Social Work, Florida International University and The Early Childhood Initiative Foundation.

THE COMMISSION ON MARRIAGE AND FAMILY SUPPORT INITIATIVES

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In accordance with s. 383.0115, Florida Statutes, the Ounce of Prevention Fund of Florida provides administrative support and serves as the fiscal agent to the commission. If you would like to make a ***fully tax deductible donation*** in support of the Commission on Marriage and Family Support Initiatives, please make your check or money order payable to: "The Ounce of Prevention Fund of Florida", specify for the "Commission on Marriage and Family Support Initiatives" and mail it to:

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Mission: *to strengthen marriages, support parents and families, and promote child well-being by raising public awareness, developing sound public policy and advocating for promising practices throughout Florida.*

FLORIDA CHALLENGES

A WHITE PAPER PREPARED FOR THE POLICY COMMITTEE OF THE COMMISSION ON MARRIAGE AND FAMILY SUPPORT INITIATIVES

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THE GOALS FOR FLORIDA

The Policy Group for Florida's Families and Children developed *The Florida Agenda* as its basis for policy and program development (Ghazvini & Foster, 2003).

> *The* ***well-being*** *of children and families is the highest priority in Florida and public policies will be established to be consistent in their support of this priority. The three key indicators of well-being are:*
>
> 1. *All of Florida's* ***children*** *are healthy, safe and ready to learn at every age.*
> 2. *All of Florida's* ***families*** *are stable, nurturing and economically self-sufficient.*
> 3. *All of Florida's* ***communities*** *are supportive of families raising children.*

This agenda was adopted by the Children's Week Initiative of One Voice for Children, the TEAM Florida Partnership, and the Commission on Responsible Fatherhood (the precursor to the Commission on Marriage and Family Support Initiatives). This agenda sets forth an articulation of the "ends" that has been agreed upon by all political ideologies. It also sets forth an ideal goal for the status of well being directly related to the strength of Florida's marriages and families.

Additionally, in 2005, The Florida Interprogram Task Force developed *Florida's State Plan for the Prevention of Child Abuse, Abandonment and Neglect: July 2005 through June 2010.* This plan sets for four goals for Florida concerning the well-being of Florida's families and children:

1. All families and communities ensure that children are safe and nurtured and live in stable environments that promote well-being.
2. State, local, and community resources comprise a collaborative, responsive, family-centered service delivery system that promotes the well-being and safety of children, families, and communities.
3. The prevention continuum has the capacity to ensure the needs of children and families will be addressed competently, collaboratively, and effectively.
4. The prevention continuum's accountability system ensures the evidence-based effectiveness of planning and resource utilization.

THE STATUS OF FLORIDA'S STRENGTHS AND CHALLENGES

Family Formation

The University of Florida conducted the *Florida Family Formation Survey* in 2003 (Karney, Garvin, & Thomas, 2003). The *Florida Family Formation Survey* describes the range of family structures in Florida, the attitudes of Florida residents towards family issues, and the correlates of healthy intimate relationships. It is based on interviews with 4,508 residents of Florida 18 years of age or older. Responses were weighted and combined to derive total estimates to describe the state of Florida as a whole and were examined by race/ethnicity and household income. Income and ethnicity were highly associated, that is, non-whites were on average far more likely to live in low-income households than whites.

Family Structures

Based on survey findings, the researchers concluded that just under a half of the family households and approximately one-quarter of the state's residents live in the traditional "nuclear" family, defined as married parents raising their biological children under one roof. "Blended" or "step" families make up just under a fifth of the state's households, whereas only 9 percent of residents cohabitate. Blacks and residents of low-income households are more likely to have difficulty in forming and maintaining relationships.

Attitudes toward Family Issues

The vast majority Florida residents place a high value on marriage. Confidence in marriage was strongest among those groups experiencing the most difficulties forming and maintaining marital relationships. Moreover, disadvantaged groups held the most traditional attitudes regarding cohabitation, premarital sex, and gender roles.

Correlates of Healthy Intimate Relationships

Relationships among disadvantaged groups were less satisfying than they were for members of advantaged groups (i.e., whites and high-income households). The researchers found that those in the least satisfying relationships experienced more financial strain and difficult life events, were more likely to have required government assistance, and had fewer sources of social support. Compared to those in satisfying relationships, they spent an average of 22 fewer hours a week in the presence of their partners.

The survey concluded that unmarried individuals want to get married, but do not feel that they have the resources to do so and do not feel that marriage to their current partner would result in a stable, life-long bond. Most are familiar with and accepting of premarital preparation and relationship counseling. Over a third of the respondents had already participated in some type of marriage preparation program, and enthusiasm for these programs was highest among disadvantaged individuals. With almost two-thirds of the respondents not having access to marriage preparations programs, and the low rates of nuclear families, there are many, many more Florida parents, potential parents and potential couples who could profit from accessible, high quality marriage preparation programs. Local community and religious organizations were viewed as the most likely sources of marriage preparation programs.

Strengths and Needs Assessments

The University of South Florida conducted the *Florida's Children: Needs Assessment 2003/2004* (CEED, 2004). Although a bit dated, the report is the most recent available for use for state wide planning efforts. This study used a resiliency framework as its foundation for investigation. The Children's Board of Hillsborough County defines resiliency as "*the potential for youth to develop into healthy, productive, competent adults despite experiences of severe stress and adversity…a quality that characterizes children who, though exposed to significant stress and adversity, do not succumb to the failures predicted for them…the innate, self-righting mechanism within every person that is engaged in active, on-going adaptation to his or her environment*" (1997). To improve child well-being and break the cycle of child abuse, abandonment and neglect, Florida must address resiliency, and the behaviors that can shore up resiliency, starting at a young age.

The Florida Office of Drug Control used a resiliency framework in its research and planning efforts. (1999) The research findings concluded that "*All young people are exposed to risk factors and all benefit from protective factors. Risk factors place individuals at greater than average risk for substance use. Protective factors buffer youth from initiating or continuing use. It is important that we do all we can to assure that protection outweighs risk for all Florida's children and youth.*" In their work, risk and protective factors were grouped into six domains:

- Individual factors
- Peer association factors
- School-related factors
- Community environment factors
- Family environment factors
- Society-related factors

Self-destructive behaviors, such as drug use and unprotected sex, have been linked to violence among college-aged individuals in relationships and to hitting and verbal abuse among adolescents just beginning to date. Adolescents who are engaging in relationship violence are more likely to continue this into adulthood. When they get into a marriage or cohabitation relationship, they are more likely to engage in domestic violence (Durant, 1999; Roberts, 2003).

Research has shown that resiliency can be built in children by providing them with protective factors at the child, family and community levels. Additionally, research has shown that resiliency is decreased by the extent to which children, families and communities are exposed to risk factors.

National Comparisons

Based on state-national comparisons for fifteen (15) indicators, Florida fared worse than the national average on fourteen (14) of them (See Table 1 below.).

TABLE 1 COMPARISON OF FLORIDA WITH THE USA ON SELECTED RISK AND PROTECTIVE FACTORS

Indicator	USA	Florida
Adults with HS diplomas (2000)	80.4%	79.9%
Births to unwed mothers (2001)	34%	39%
Child death rate (2000)	22 *per 100, 000*	24 *per 100,000*
Children in divorced households (2002)	9.7%	11.6%
Children in poverty (1999)	17.1%	18.5%
Children in poverty with health insurance (2002)	92.1%	89.4%
Crowded housing (2000)	5.6%	6.5%
Dropout rate (2000)	9%	12%
Infant mortality rate (2000)	6.9 *per 1,000*	7.0 *per 1,000*
Low birthweight rate (2000)	7.6%	8.0%
Percentile of church attendance (2002)	50	53
Stability (5-year stay) in housing (2000)	54.1%	48.9%
Teen birth rate (2000)	27 *per 1,000*	29 *per 1,000*
Two-parent households (2000)	23.6%	19.2%

The dates for data reported are reflected in parentheses.

Of the nine (9) indicators of risk factors that put Florida's children and families at risk, Florida fared worse than the national average for:

- Births to Unwed Mothers as measured by the number of births to unwed mothers divided by the total number of births.
- Child Death Rate as measured by the number of children that die before their fifth birthday, divided by the total number of children under five years old. Child death rate is a parallel indicator for child abuse.
- Children in Poverty as measured by the number of children in poverty under age 18 divided by total number of children under 18 years old. Economic security and employment consistency are protective factors for child well-being.
- Children Living in Divorced Households as measured by the Crude Divorce Rate per 1,000 Population – The total number of divorces, during a given year, divided by the total population. *Note: This is a point-in-time measure, and does NOT represent the proportion of divorced persons in the population. It is used as the best available proxy measure for the proportion of children living in divorced households.*
- Crowded Housing as measured by the number of housing units with 1.01 or more occupants per room divided by the total number of housing units. Homelessness and inadequate housing are risk factors for child maltreatment.
- Dropout Rate as measured by the number of students who drop out of high school, divided by the October school membership. It includes students who voluntarily exit from the school system before graduation for whatever reason; do not meet the relevant attendance requirements of the school district; withdraw from school, but have not transferred to another public or private school or enrolled in any career and technical, adult, home education, or alternative educational program; or are not

eligible to attend school because of reaching the maximum age for an exceptional student program in accordance with the district's policy.

- Infant Mortality Rate (Per 1,000 Live Births) as measured by the number of infants that died before their first birthday, divided by the total number of births during the same period.
- Low Birthweight Rate as measured by the number of low weight births (under 2,500 grams) divided by the total number of births. *Note: 2500 grams is approximately 5 1/2 pounds.* Low birthweight is a risk factor for developmental delays and child maltreatment.
- Teen Birth Rate as measured by the number of births to girls between the ages of 15-17, divided by total number of girls between 15-17. Low maternal age is a risk factor for low birthweight, which is in turn a risk factor for developmental delays and child maltreatment.

Of the four (4) protective factors that could have helped to ensure resilience for Florida's children, Florida fared worse than the national average for:

- Adults with High School Diplomas as measured by the number of population older than 25 years that have at least a high school diploma (including a GED), divided by the total population aged 25 and above. Higher level of maternal education is a protective factor for child well-being.
- Children Living in Poverty with Health Insurance as measured by the number of children under 200 percent of poverty under age 18 with health insurance divided by total number of children under 200 percent of poverty under 18 years old. Access to quality health care is a protective factor for child well-being.
- Stability of Housing as measured by the number of the population over age 5 living in the same house since 1995 divided by the total population over age 5. Safe and cohesive neighborhoods with routine and consistency in family life are protective factors for child well-being.
- Two Parent Households as measured by the number of households headed by married couples with their own children under age 18, divided number of the population over age 5 living in the same house since 1995 divided by the total population over age 5. Safe and cohesive neighborhoods with routine and consistency in family life are protective factors for child well-being.

State Trends

In Florida, the rate of child maltreatment increased by 37 percent between 1998 and 2002. In absolute terms, this represents a 49 percent increase in the number of children abused.

One of the greatest indicators of a family's ability to cope with adversity and provide a safe, nurturing environment for its children is the rate of child abuse and neglect. Child abuse and neglect occur for a variety of reasons: caregivers' drug abuse or mental health problems; their difficulty in coping with extreme poverty or stress and lack of a natural support system; they may be victims of domestic violence, they may have been victims of maltreatment as children, or they may be dealing with a combination of all of these. No matter what the reason, the end result of child abuse and neglect is devastating — and sometimes deadly — for the victims. (Children's Services Council of Palm Beach County, 2002)

Although maltreatment affects all ages, statistics published in 2001 by the US Department of Health and Human Services show that children in the birth to three-year-old age group had the highest victimization rates of all age groups. Independent of poverty, gender, and race, arrest rates for victims of maltreatment are substantially higher than those of comparable children not subjected to maltreatment. They have higher rates of non-traffic arrests, including violent crimes, higher rates of suicide attempts and higher rates of prostitution and alcoholism among females. (Travis, 1996)

The US spends an estimated $92 billion per year on costs resulting from child maltreatment, including direct costs (hospitalization, mental health care, foster care, law enforcement) and indirect costs associated with long term effects (special education, juvenile delinquency, lost productivity, adult criminality). These figures do not include welfare benefits to adults whose economic condition is a direct result of abuse and neglect suffered in childhood. (Fromm, 2001)

** The Administration for Children and Families (HHS) calls this the Victimization Rate, and defines it as the number of victims of child maltreatment divided by the state's child population (0-17), multiplied by 1,000. Victims are defined as children that are the subject of substantiated or indicated maltreatment. It is a better indicator of the incidence of abuse than is the number of calls to the hotline, as many calls result in allegations deemed to be unfounded. The rate is expressed per thousand children in the population. Source: http://www.acf.hhs.gov/programs/cb/publications/cmreports.htm*

In Florida, the re-abuse rate was 8.7 percent in 2002, a 6 percent increase since 1998.

A considerable effort is involved at the local level to protect children, with the ultimate goal of permanency for every child. Sometimes a placement that appears to be in the best interest of the child puts the child at further danger. In such a case, the child is abused again within the first half-year of the placement decision. In an ideal world, no child would be re-abused. The national goal standard is for re-abuse to be limited to a maximum of 6.1 percent. The re-abuse rate dropped substantially in 2000, but has risen since and is now 6 percent higher than the 1998 rate and is 2.2.6 percent higher than the national goal standard.

** This indicator represents the number of children that had another substantiated or indicated report of child maltreatment within a six month period of an initial report, divided by the number of children maltreated. Source: http://www.acf.hhs.gov/programs/cb/publications/cmreports.htm*

In Florida, the child poverty rate has decreased by 4.1 percent from 1998 to 2002. Although the rate is decreasing, in 2002, there were 3.75 million children in Florida who were living in poverty.

Children living in poverty are 22 times more likely to be victims of maltreatment than children from wealthier families. Children living in poverty are also over represented with respect to a multiplicity of poor outcomes: abuse and neglect, school failure, joblessness, delinquency, mental illness, violent death. *Poverty is the single greatest predictor of academic and social failure in America's school children (emphasis added).* Persistent poverty constrains family access to food, housing, health care, social support, and transportation. Children in mother-headed households are more than four times likely to live in poverty as children in the general population. (U.S. Dept. of Education, 2001)

Minorities and non-citizens are disproportionately poor. Thirteen percent of non-citizens are workers who live in low-income families with children compared with 4.3 percent of whites and 9.9 percent of blacks in the general population. Even though only 7 percent of all workers are non-citizens, almost 20 percent of all low-wage workers who live in a low-income family with children are noncitizens. (Lawton and Rhea Chiles Center, 2003)

* *Child poverty is measured by children under age 18 in poverty divided by total number of children under 18 years old. Source: http://www.census.gov/hhes/www/saipe/stcty/d00_12.htm*

The Florida Department of Children and Families reports that the rates of tobacco use among the state's high school students is 22.6 percent for 8th graders, 27.6 percent for 10th graders, and 31.4 percent for 12th graders. This compares to national rates of 19.1 percent for 8th graders, 27.9 percent for 10th graders and 33.5 percent for 12th graders.

The current use rates for tobacco among our youth are slightly higher than the national average, and are significantly higher among those on the verge of entering high school. It is the significant difference between the 8th graders that pushed the overall rate of Florida's current use rate for tobacco above the national average. Research has also found a correlation between underage use of tobacco and the use of cocaine and heroin later in life. Further, women who use tobacco during pregnancy have a higher likelihood of going into pre-term labor and having children who have low birth weights. (Florida Office of Drug Control, 1999)

* *Tobacco use is defined as having used tobacco within the past 30 days. Source: http://www.myflorida.com/myflorida/government/government initiatives/drugcontrol/strategy.html.*

In Florida, 26.4 percent of 8th graders, 39.8 percent of 10th graders and 52.4 percent of 12th graders report that they consume alcohol. Further, 12.7 percent of 8th graders, 20.6 percent of 10th graders and 29.9 percent of 12th graders report binge drinking.

Among 6th to 12th graders, 55.1 percent have consumed alcohol in their lifetime; 30.9 percent have consumed alcohol in the past 30 days with grade level results ranging from 11.2 percent for 6th graders to 52.4 percent for 12 graders; and 16 percent reported binge drinking (consumeing 5 or more drinks in one setting) averaging 8.3 percent for middle school

students and 22.3 percent for high school students. (The 2003 Florida Youth Substance Abuse Survey (FYSAS))

* *Alcohol use is defined as having consumed alcohol within the past 30 days. Binge drinking is defined as having consumed five or more drinks per day. Source: http://www.myflorida.com/myflorida/government/government initiatives/drugcontrol/strategy.html.*

The Florida Department of Children and Families reports that 15.7 percent of Florida teenagers are using illicit substances. The national teen current use rate is 11.4 percent according to the Office of National Drug Control Policy (ONDCP).

Although there are limited Florida data on the extent of current use for those aged 18 and older, using the difference in Florida's current use rate among teens, and the national teen current use rate of 11.4 percent, Florida's current use rate for those aged 12 and older is estimated at between 7.5 and 8 percent. With its current population of over 17 million people, Florida is estimated at having over 1 million current users. This figure represents almost 7.2 percent of all users in the country. (Source: Florida Drug Control Strategy 1999-2005 dated August, 1999)

* *A current user is defined as an individual that has used any illicit substance within the past 30 days. Binge drinking is defined as having consumed five or more drinks per day. Source: http://www.myflorida.com/myflorida/government/government initiatives/drugcontrol/strategy.html.*

Florida's low birth-weight rate has increased steadily over the last five years, growing by almost 4 percent. In absolute numbers there has been an increase of nearly 13 percent in the number of babies weighing less than 2,500 grams.

Babies born too small or too soon are no longer condemned to an early death. More and more of them are surviving. However, these children are disproportionately at risk for chronic health problems and developmental delay, which place extra demands on family resources and increase parental stress levels. Annual costs for underweight babies have been placed at $25,000 per child (in 2003 dollars) from birth through age 18 (Annie E. Casey Foundation, 2003).

Low birthweight may be the result of prematurity, or it may be the result of stunted growth during a full-term pregnancy. Many factors contribute to low birthweight. Having no prenatal care or having late or inconsistent prenatal care puts a woman at risk. Teen mothers frequently give birth to at-risk infants, as do mothers in their twenties who began their child-bearing in their teens and have their babies too close together. Mothers who smoke or use drugs are disproportionately likely to have low birthweight infants that will need to be treated in intensive care units. The need for such treatment adds additional stress to the family and increases the consumption of health care resources allocated to care for children. Substance exposure in utero has been linked to developmental delay and increased behavior problems in young children; both factors are linked to an increase in child maltreatment.

* *This indicator measures the number of low weight births (under 2,500 grams) divided by to the total number of births. 2,500 grams is approximately 5½ pounds. Source: http://hpeapps.doh.state.fl.us/phids/ Phids1.asp, also published in Florida's Children*

In Florida there has been a steady increase in births to unwed mothers. The 2001 rate was 8 percent higher than the 1996 rate, but this reflects an 18 percent growth in the absolute number of children born to unmarried women.

Most data that exist relate to the number of parents with whom a child lives, rather than the marital status of the mother. The majority of unmarried women giving birth are *not* teens. However, children in mother-headed households are more than four times as likely to live in poverty as children in the general population (US Department of Education, 2001). And, children in ... single parent families are at increased risk for poor school marks, repeated grades, increased likelihood of dropping out of high school, early childbearing, and increased levels of depression, stress, anxiety and aggression (Fields et al, 2001).

** This indicator represents the number of births to unwed mothers divided by the total number of births. Source: http://hpeapps.doh.state.fl.us/phids/Phids1.asp, also published Florida's Children at a Glance.*

IMPLICATIONS OF THIS WORK FOR FLORIDA

The implications of the findings of the ***Florida Family Formation Survey*** and these conclusions are five-fold:

1. No single approach to supporting healthy families is likely to be effective for all families. Programs and policies that target families will have to take the unique needs of different kinds of families into account.
2. Programs that merely promote the value of marriage and stable families are unlikely to change behaviors. To increase effectiveness, resources should be devoted toward helping individuals overcome the obstacles that may prevent them from acting in accordance with the values they already possess.
3. Relationship preparation, education and counseling must take the circumstances of people's lives into account. Programs and policies should target processes within the family and the distressed environments in which they unfold.
4. Programs and policies that improve the general quality of people's lives are likely to improve the quality of their marital and family relationships as well. The health of families is closely tied with the health of the economy.
5. Religious and community organizations can provide a ready infrastructure for building venues for implementing programs directed at supporting families and relationships.

The implications conclusions of the findings of Florida's strengths assessments, needs assessments and planning efforts are far reaching and challenging. With the maltreatment rate on the rise, planners would benefit from examining data on victims and perpetrators of abuse, coupled with census economic and demographics data, to place broad-based family support resources where they are most likely to produce positive results. The at-risk profile includes low-income males under the age of ten, living in households with large numbers of children and a single, uneducated parent. The needed broad-based support would include resources across the four domains (Economic, Education, Health and Safety, and Socio-Emotional), in addition to parenting classes, childcare and respite care.

The proportion of children removed from parental homes may also be on the rise, although a change in the way this proportion is computed makes it difficult to determine. If it has in fact increased, the focus of future interventions might more effectively include the extended family of at-risk children, including non-relative community support systems such as faith communities, mothers' groups, neighborhood/block associations, clubs/troops/social organizations. These types of "extended family" may be in a position to provide the respite and parental supports necessary to enable a child to live and thrive safely in a parental home. According to federal statistics, the re-abuse rate is on the rise. The state's Program Improvement Plan (PIP) developed by the Florida Department of Children and Families focuses on safety for children and reflects strategies that have been put into place to address re-abuse. Until the rate stabilizes or improves, internal Department Quality Improvement efforts might want to direct special attention to counties with low re-abuse rates to see which critical components of their processes can be readily adapted by counties with poor outcomes.

With out-of-school suspensions on the rise, Florida Department of Children and Families and Department of Education could jointly foster partnerships that forge supervised, capacity-building alternatives for these at-risk young people at both the state and local levels. With low birth weight on the rise, Florida Department of Children and Families might consider partnering with the Florida Department of Health and the Healthy Start Coalitions at the state and local levels, as has been done with Healthy Families Florida. These partnerships could ensure that women of childbearing age who are served by the Department have access to well-woman care, prenatal care, and WIC food supplements so that conditions contributing to poor birth outcomes can be addressed early.

With the increase in unwed births, it might be fruitful to look at the age and geographic distribution of these births in counties most affected. There may be room for partnerships with the statewide marriage and family support initiatives, as well with organizations established by and for women professionals.

To achieve long-term reductions in drug-use rates will require reducing risk factors and increasing protective factors for children and their families. With substance abuse problems affecting so many families, individuals, communities and the workforce at different levels, coordination and cooperation between state agencies and organizations and between state level and local level agencies must be deliberate and ongoing. These agencies and providers must communicate with each other, local partners, and the media and the public

Implications of this Work for the Commission on Marriage and Family Support Initiatives

Through the work of its clearinghouse, the commission should consider the publication of a series of research briefs and white papers regarding the effects of poverty, violence and substance abuse on Florida families. These publications could lend themselves toward making policy recommendations and providing research-based intervention strategies that assist families in dealing with these stressors in order to achieve better child development and well-being.

As part of this effort, the commission could identify and recommend developing integrated service delivery models at the state and community levels that avoid the fragmentation of so many service entities that tend to overwhelm Florida families. Achieving a family friendly and integrated approach will assist families seeking help at the front end with these stressors at individual, family and community levels; thus ameliorating the need for more costly deep end services at the back end.

The commission should also prepare submissions for its statutorily required clearinghouse regarding marriage and parent education. The commission should work to inform Florida citizens regarding research on marriage and family formation and how best to make choices regarding couples' relationships that lead to healthy and happy marriages and positive child development.

The commission should consider development of a publication outlining and highlighting successful elements of parent education and marriage education service delivery. The commission could utilize its staff, individual commissioners, and talented professionals from the research and provider communities to help determine what these essential or successful program elements should be.

PRIMARY AND SECONDARY REFERENCES

Annie E. Casey Foundation. (2003). *Kids Count Data Book*, Baltimore MD.

CEED (2004) *Florida's Children: Needs Assessment 2003/2004*, Tallahassee, FL. Community Enhancement and Educational Development Program of the Lawton and Rhea Chiles Center for Healthy Mothers and Babies. Online at *http://www.teamfla.org/downloads/Spring2004NeedsAssessment.pdf*

CEED (2005) *Florida's State Plan for the Prevention of Child Abuse, Abandonment and Neglect: July 2005 through June 2010*, Tallahassee, FL. Community Enhancement and Educational Development Program of the Lawton and Rhea Chiles Center for Healthy Mothers and Babies. Online at *http://www.teamfla.org/downloads/Plan/PCAANsummary-web.pdf.*

Children's Board of Hillsborough County. (1997). *A Conceptual Framework for Service Planning for Children and Families*, Tampa FL.

Children's Services Council of Palm Beach County. (2002) *State of the Child in Palm Beach County*, West Palm Beach, FL. Online at *http://www.cscpbc.org/Misc_PDF_Files/SOC.pdf*

Durant, R. H. (1999). Cited by Defino, T., *Date Fighting Linked to Drug Use, Other Destructive Behaviors in Teenagers*, WebMD. Online at *http://content.health.msn.com/content/article/20/1728_53331.*

Fields, J., Smith, K., Bass, L. E., & Lugaila, T. (2001). A Child's Day: Home, School and Play – Selected Indicators of Child Well-Being, *Current Population Reports*, Washington, DC: US Government Printing Office. Online at *http://www.census.gov/prod/2001pubs/p70-68.pdf.*

Florida Department of Children and Families, Florida Prevention System (2004), *A Vision for the Prevention Component of the Florida Drug Control Strategy.*

Florida Department of Children & Families. (2004). "2004 Florida Youth Substance Abuse Survey: State Report." Tallahassee, FL. Online at http://www.dcf.state.fl.us/mentalhealth/publications/fysas/

Florida Office of Drug Control, "*Changing Alcohol Norms (CAN): Florida's Initiative to Lower Youth Drinking - A White Paper,*" April, 2004. Online at *http://www.myflorida.com/myflorida/government/government initiatives/drugcontrol/strategy.html.*

Florida Office of Drug Control (1999), *Florida Drug Control Strategy 1999-2005.* Online at *http://www.myflorida.com/myflorida/government/government initiatives/drugcontrol/strategy.html.*

Fromm, S. (2001). Estimated *Annual Cost of Child Maltreatment.* Chicago: Prevent Child Abuse America.

Ghazvini, A. S., & Foster, B. (2003*). The Florida Agenda,* (#2003-B006). Tallahassee, FL: The Policy Group for Florida's Families and Children. Online at *http://www.policygroup.org/agenda.htm*

Karney, B. R., Garvin, C. W. & Thomas, M. S. (2003) *Family Formation in Florida - 2003 Baseline Survey of Attitudes, Beliefs, and Demographics Relating to Marriage and Family Formation.* Gainesville, FL The University of Florida. Online at *http://www.phhp.ufl.edu/~uspringe/FMP/Publications/REPORT.pdf*

Lawton and Rhea Chiles Center for Healthy Mothers and Babies. (2003). *Refugee and Entrant Project Newsletter*, July 2003, Tallahassee FL.

Roberts, T. A. & Klein, J. (2003). Intimate Partner Abuse and High-Risk Behavior in Adolescents, *Archives of Pediatric Adolescent Med,* 157:375-380.

Travis, J. (1996). National Institute of Justice Research Preview, *The Cycle of Violence Revisited*, online at http://ncjrs.aspensys.com/pdffiles/cyclepre.pdf. US Department of Education, *23rd Annual Report to Congress on the Implementation*

US Department of Education. (2001). *23rd Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*, Washington DC: Government Printing Office.

THE COMMISSION ON MARRIAGE AND FAMILY SUPPORT INITIATIVES

Created in 2003 (s. 383.0115, Florida Statutes), the ***mission*** of the Commission on Marriage and Family Support Initiatives is to strengthen marriages, support parents and families, and promote child well-being by raising public awareness, developing sound public policy and advocating for promising practices throughout Florida. For more information about the commission, visit its website at ***www.floridafamilies.org*** or contact:

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Perpetrator Risk Factors for Child Maltreatment

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Summary of Findings from the Literature

- As the primary provider of child care, females are the perpetrators in most cases of maltreatment.
  - Among female perpetrators, 86 percent are biological mothers.
  - Slightly less than one-half of all perpetrators are male.
  - Of these, approximately half are biological fathers, an additional one-fifth occupy some other parental role (adoptive fathers, stepfathers, mothers' boyfriends), and about one-quarter are in nonparental relationships (including relatives, foster parents, day care providers, or friends) to their victims.

Summary of Findings from the Literature

- Neglect and medical neglect are most often attributed to female perpetrators.
- Male perpetrators who are not biological fathers are more commonly associated with physical abuse and sexual abuse, older children, and female children.
- Biological fathers are more likely to maltreat young children (i.e. infants and children under age 3), more likely to maltreat both girls and boys, more likely to be involved in neglect cases.

Domestic Violence and Child Maltreatment

- According to published studies, there is a 30 percent to 60 percent overlap between violence against children and violence against women in the same families.
- Children in violent homes face three risks:
  - Risk of observing traumatic events
  - Risk of being abused themselves
  - Risk of being neglected

Substance Abuse and Child Maltreatment

- Children of substance-abusing parents are almost 3 times likelier to be abused and more than 4 times likelier to be neglected than children of parents who are not substance abusers.
- Other studies suggest that an estimated 50 percent to 80 percent of all child abuse cases substantiated by child protection services involve some degree of substance abuse by the child's parents.

Poverty and Child Maltreatment

- While children of families in all income levels suffer maltreatment, research suggests that family income is strongly related to incidence rates.
- Children from families with annual incomes below $15,000 per year were more than 25 times more likely than children from families with annual income above $30,000 to have been harmed or endangered by abuse or neglect.

Services and Child Maltreatment

- Studies find that post investigation services are provided more often with female perpetrators than with male perpetrators.
- Recidivism rates are highest for biological fathers, mother's boyfriends, and nonparents, and lowest for adoptive fathers and stepfathers.

Child Abuse Death Review – Perpetrator Risk Factor Study

- Funded by the Department of Children & Family Services, Task Force for Children's Justice Act
- Collaboration between the Florida Department of Health and Louis de la Parte Florida Mental Health Institute
- Goal:
  - Identify common characteristics of child abuse perpetrators to determine what risk/protective characteristics are present in various situations.
- Objectives:
  - Clarify critical information needed when reviewing cases to determine appropriate interventions.
  - Devise effective prevention programs based on empirical findings.

Child Abuse Death Review – Perpetrator Risk Factor Study

- Methods:
  - Record reviews of maltreatment cases in the State of Florida for a period of four years, 1999-2002.
    - Group A: Cases reviewed by the Child Abuse Death Review Team (CADR). These are cases of children who have died as a result of child abuse and neglect who also had at least one prior report of child abuse or neglect.
    - Group B: Nonfatal cases in which children were removed from their homes due to abuse or neglect, but subsequently reunited.
    - Group C: Nonfatal cases in which child abuse or neglect was verified, but the children were not removed from their homes.

Child Data

- Age
- Gender
- Race/Ethnicity
- Presence of MH disability, physical disability, or developmental delay
- Chronic medical needs
- Engagement with community social service agencies
- Enrollment in school/daycare

Incident Data

- Witnesses (adult, child)
- Other child victims
- Location (in home, out of home)
- Date/time of incident
- Potential catalyst
- Type of incident

Perpetrator Data

- Demographics
- Relationship to child
- Educational level
- History of Domestic Violence and Prior Acts of Child Abuse
- Employment Status
- History of Substance Abuse and MH illness
- Criminal history
- Childhood history

Household Data

- Prior reports of abuse
- History of service use
- Community visibility factors
- Family stress factors
- History of non-offending caregiver
- Family structure

Focus of Analysis

- Demographic characteristics of both perpetrators and victims
- Relationship of the perpetrators to the child victims
- Whether the perpetrator acted alone or with another person
- Circumstances of the maltreatment

Preliminary Findings Based on Cases of Fatal Child Abuse in Florida

- Cases are nearly evenly divided between abuse related deaths and neglect related deaths.
- The majority of children in the sample (63%) were at home at the time of death.
- In 32% of cases either an adult or a child witness was present.
- In cases of fatal child abuse, female perpetrators are more often involved in cases attributed to neglect while male perpetrators are more likely to engage in physical abuse leading to the child's death. If the perpetrator is a male then a child is twice more likely to die as a result of abuse versus neglect.

Preliminary Policy Implications

- Prevention and treatment interventions for child maltreatment need to be differentially targeted toward various populations in order for a large proportion of perpetrators to benefit from these efforts.
  - For example, in-home services may be missing the opportunity to involve men who maltreat children but are not living in the home.

- For additional information on this study, please contact:

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